Expressive and Creative Arts Methods for Trauma Survivors

Edited by
Lois Carey

Foreword by Judith Rubin

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Foreword

> Man creates, as it were, out of his mortal wounds.
>
> *Joost A.M. Meerloo, M.D. (1968, p.22)*

From time immemorial, people of all ages have turned to play and to the arts to deal not only with the stresses of everyday life, but also to cope with trauma-experiences that are too overwhelming for the ego to assimilate. From the soothing of David's biblical harp to the catharsis of classic Greek drama, the arts have offered solace to those under stress. Children play doctor, adolescents write poetry, and this very fact, that creative activity is therapeutic, is the main reason for the existence of the expressive arts therapies as helping professions.

Art therapy, for example, has its roots in the art of the mentally ill, itself a response to the terror of psychosis—a loss of contact with both the self and the world. Some events are so devastating that words fail, and the arts become the best way to say what presses for release. In the spontaneous reaction to the attacks of 9/11, people of all ages created drawings, murals, and shrines, not only in New York but around the world (Rubin 2004).

Whether the trauma is a sudden shock or a prolonged strain, the arts can help. In fact, making creative activities available to people who have suffered trauma is a form of "secondary prevention"—helping those who are at increased risk for psychological problems. Like medicating at the first sign of an infection, offering the arts to people who are in the throes of responding to overwhelming events may well prevent more serious and prolonged emotional damage.

Even later, creating can be healing. Thirty years after an atomic bomb fell on Hiroshima, a television station asked survivors to send in pictures of their memories. They were astonished by the response, as hundreds of adults welcomed the opportunity to deal with the still painful experience by creating images (Japanese Broadcasting Corporation 1977).

That art can give meaning to a life twisted by trauma was eloquently demonstrated in the paintings of Frida Kahlo, whose spine and pelvis were shattered in an accident at age 18, leaving her with chronic pain and constant threat of illness. As she once said, "The only thing I know is that I

paint because I need to" (Herrera 1983). Frida's paintings were silent screams, emitted while she endured repeated traumas—abortions, operations, and months in bed with a body cast. At the end of her life, the poems and pictures in her diary (Kahlo, Fuentes, and Lowe 2001) were a creative way of coping with a leg amputation and awareness of impending death.

A massive shock to the system, whether physical, psychological or both, elicits powerful feelings for which words are inadequate, yet image, sound, movement, and story can offer a welcome release. The arts help both to *express* and to *contain* otherwise overwhelming emotions. In this book, experts in play therapy and the arts therapies describe the physiological and psychological effects of trauma, along with a wide variety of creative ways to treat its survivors.

That trauma often involves and resides in the body is well known. That it can occur before a child has language, or can render the victim psychically speechless, is also common knowledge. For these reasons, and because of the frequent injunction by abusers not to tell, memories of traumatic experiences are difficult, if not impossible, to access with verbal therapy alone.

It is no accident that even clinicians not trained in the creative arts therapies, when faced with the daunting task of helping severely traumatized clients, have discovered that drawing, sandplay, moving, singing, or using puppets can help to unlock painful secrets, unknown even to the individual involved (Rubin 2005a). Equally important, and vividly demonstrated in the case examples and vignettes in this book, the arts are powerful tools in the processing, metabolizing, and assimilating of the toxic effects of trauma that linger, fester, and affect the developing brain (Solomon and Siegel 2003).

I once treated a child who had witnessed an unbearable sight at age five: her mother shooting and killing her younger brother (Rubin 2005b). Jackie suffered from nightmares and intrusive waking imagery. She was also lonely, because her grumpiness alienated others. Like most children with abusive parents, Jackie could not safely acknowledge or feel anger at her mother. She was afraid of losing what little good feeling she clung to on her rare visits to the jail.

But she could safely direct her rage at me as the mother in the transference in "ugly" drawings of "Dr. Rubin's face." For weeks, she put signs on my office door, warning other children not to believe what I said, and—projecting her own neediness onto me—accusing me of being "a beggar." In this way, Jackie was able to work through her confused feelings about herself and

others, eventually integrating good and bad images of both of us, and leaving therapy with a warm attachment.

By the time adult survivors of abuse seek treatment, they usually have problems in many areas, and often carry multiple psychiatric diagnoses. Art therapist James Consoli created an approach he called "psychimagery" (1991), in which he employed hypnosis, mental imagery, and art to help patients recover repressed memories.

Art therapist Linda Gantt and psychiatrist Louis Tinnin have developed a unique approach at the Trauma Recovery Institute, where they use drawings to fill in memory gaps, processing events by putting the images in chronological order and "re-presenting" them to the client. Like many authors in this book, they also use other modalities, such as hypnosis and video, to help clients safely re-experience and work through the lingering effects of traumatic experiences (Tinnin, Bills, and Gantt 2002).

Elaine was a middle-aged woman who had suffered from depression all her life. She was referred for art therapy because, when she started to remember her own abuse, she could not talk about it, but could only "say" it in finger paintings. In art therapy, work in clay and paint slowly brought forth even more memories. For Elaine, art therapy became a way of finding out what was inside in a place that felt increasingly secure. She called the therapy space a "holding environment," a term coined by Winnicott (1971), and gave that title to one of her sculptures, in which a person holding an infant (her small victimized self) leans against a well-rooted tree, her favorite symbol for support.

After many years of work, it was hard for Elaine to say goodbye, even though she had made a good attachment to another therapist. She took most of her art work home, but left a good deal with me, too, as a "transitional object" (Winnicott 1971). In her last session, Elaine made a sculpture that reminded me of her "holding environment" of four years earlier. The tree had not been in her work for a while, perhaps because she felt more "grounded" internally. In its place was a hand, cradling a person holding a baby. She called it simply "*Therapy*."

Beverly uncovered deeply repressed memories of sexual abuse by her father during her analysis. She wrote in a journal between sessions, and began to paint and draw as well, to contain and process the overwhelming emotions engulfing her. After his death, she wrote a powerful poetic memoir, bringing it into her sessions as it emerged. By creating within the therapeutic relationship, she was finally able not only to remember, but also to work through, and eventually to master the effects of what she had endured.

Although most of the case examples in this volume describe work with children and adolescents, there is no age limit for healing facilitated through the arts therapies. They are indeed a way of "telling without talking" (Cohen and Cox 1995). Child, adolescent, and adult survivors need the languages of all of the arts not only to overcome repression, but to adequately express that which is unspeakable, as therapist Alice Miller (1986) discovered for herself in her own paintings.

One of the most useful aspects of this book is the range of methods and modalities described by the authors, all of whom are experienced clinicians. Many different theoretical approaches are represented, from psychodynamic to cognitive-behavioral, from humanistic to bioenergetic, in the context of work with individuals, families, and groups. An equally wide variety of technical approaches is described: music, art, play, sandplay, puppetry, drama, video, and storytelling.

Today, through neuroscience (Solomon and Siegel 2003), we can better understand *why* the arts are so therapeutic—that in order to master trauma, it is necessary first to access the nonverbal right hemisphere (through images, sounds, and movements); and then to enable it to communicate with the left, in order to gain cognitive and affective mastery. Thanks to the disciplines of the expressive arts therapies, in the hands of experienced clinicians, patients of all ages can play and create their way to mental health.

Judith Rubin
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Introduction

Lois Carey

This book focuses on children and adults who have survived one or more traumatic experiences and describes various methods of healing that therapists have found to be effective. I am deeply indebted to the authors whose work is included in this book and wish to thank each for their contribution. All are renowned experts in their own expressive and creative arts fields and each has previously published work with trauma victims. I personally believe that this type of therapy is "soul work" and that many practitioners who work with creative avenues of expression are true healers who have done their own reparative work on their own personal issues.

Research by van der Kolk (1987), van der Kolk, McFarlane, and Weisaeth (1996), Siegel (1999), and others has ascertained that the neurobiological basis of trauma has a direct effect on treatment methods, whether the client is an adult or a child. This is amply discussed by Dr. David Crenshaw in Chapter 1 of this book.

When we speak of trauma, we must first ask, "What is trauma? How is it defined?" According to *Webster's New World Dictionary* (1970) the psychiatric definition is "a painful emotional experience, or shock, often producing a lasting psychic effect and, sometimes, a neurosis." Trauma covers any situation where one's psyche is overwhelmed to the point that the person is unable to use his or her usual psychological defenses, or to function in the usual fashion.

In Chapter 2, Dr. Nancy Boyd Webb discusses the various types of trauma and suggests positive methods that are useful in treatment. Dr. Webb indicates that some situations that constitute trauma are related directly to the experiences of the individual; others relate more to society. For example, signs of personal trauma can be seen in children who have been physically,

sexually, or emotionally abused, who have been neglected and/or exposed to domestic violence, who have lost a parent, sibling, or other family member through divorce or death or suicide.

For the adult survivor, many who were abused as children are only now dealing with the long-buried effects of trauma that are sometimes triggered by a more recent event. Adults who survived 9/11 or are Iraqi (or other) war veterans, are trauma sufferers. In addition, the children of Holocaust survivors often unconsciously carry the trauma of their parents (van der Kolk 1987). As this is being written, people in London have had suicide bombings in three of their undergrounds and one bus. The relatives and survivors of these events will undoubtedly suffer trauma.

Why have trauma and violence achieved such major proportions today? These are not new situations. History holds numerous examples of violence—the conquistadors, the Salem witch trials, multitudinous numbers of wars, the mythologies of the Greeks, Romans, and Egyptians, the Bible. Some of us have grown up exposed to a great deal of traumatic material and have managed to cope, while many children today seem to be seriously affected. It may be that we are more aware of children's problems today, because the general public is more attuned to mental health issues than in the past, and seek out therapy before major problems have a chance to develop.

Many children today are brought for therapy, many with histories of aggression towards peers, bullying, poor social skills, anxiety, depression, and so on, as their presenting problems. As a therapist who has treated children and families for more than 30 years, it appears to me that children have forgotten how to play, and are being overexposed to violent computer games and news on TV. Others have experienced family break-ups and have overly programmed activities in attempts to fill this void. Still others have two working parents, single parents, grandparents as parents—the list can go on and on. Instead of "just playing," children are enrolled in Tai Kwan Do, soccer, T-ball, dance, swimming, football, wrestling, tennis, horseback riding, etc. There appears to be no time for idling away a day in playing alone with dolls or soldiers, making mud pies, or dressing up.

Therapists cannot possibly hope to change the violence in our world or to alleviate traumatic situations. What we can do is to be prepared to deal with the world as it is and as it affects today's victims. This requires that we be sensitive, caring, knowledgeable about different methods of treatment and, most especially, creative. We need to understand that each individual is

unique and that we must tailor treatment of each one's therapy in the best way that we can.

Many children under the age of eight or nine have great difficulty in using words that describe feelings. This is especially true for children who have been traumatized. One of the tasks of therapy is to help them find ways to express their feelings through alternative methods of expression such as art, drama, music, sand, and others, in addition to verbalization. The chapters in this book are devoted to expressive/creative techniques that are available to treat not only the child, but also the adult who has been traumatized.

Modalities such as these immediately lessen a person's anxiety and allow him or her to accept therapy and begin to form a relationship to the therapist. It must be noted that some traumatized children evidence signs of what Eliana Gil (1991) called "posttraumatic play," a stylized form of play that has unique characteristics: it is repetitive, literal, and rigid. There is an unconscious link between the play and the event, which fails to relieve anxiety for the child and often depicts danger. There is a notable lack of spontaneity or fun, and the child is immersed in the play to the exclusion of the therapist. This kind of play clearly signals that attention must be focused on the trauma material. Otherwise the child may feel more deeply traumatized, and may experience feelings of increased vulnerability and helplessness. This is one instance where the therapist needs to take a more directive role in leading the child to the traumatic material (which the child is trying to avoid), rather than staying with a child-centered format.

The therapeutic relationship is the cornerstone of all effective treatment, according to van Der Kolk (1987), Gil (1991), Carey (1999), Webb (2004), and many others. The therapist and the patient are both confronted with intense emotional experiences that range from helplessness to revenge, from vicarious traumatization to vicarious thrills. Traumatic injury is a very difficult area to treat and one that calls for careful diagnostic screening. The symptoms exhibited by many survivors of trauma (men, women, and children) are depression, anxiety disorders, dissociation, and substance abuse. Somatic symptoms can also be prevalent. It is hoped that treatment will be a positive experience for the client so that feelings of "safety," so essential to healing, can be implemented as soon as possible. This means that the child (or adult) needs to have experienced a secure, loving relationship with their mothering figure before the trauma occurred. This is especially necessary in order for a positive therapeutic relationship to develop. It must *feel* safe to the child or adult for therapy to be healing and effective.

Beginning steps

In the beginning stages of trauma treatment with children it is important to talk to them at a level they can understand, and to assure them of their physical safety. Children under the age of 11 are most at risk of the effects of trauma. Parents need to be aware of any behavior changes, night-time fears, unusual startle responses, or fears of wind or rain. Some children refuse school, suffer headaches, develop stomach-aches, vomit, or run a fever. Activities that are helpful to ease the anxiety are drawing, painting, writing a story of the event, using clay or play dough, making music, or playing with puppets. Many traumatized individuals become fixated at the stage when the trauma occurred, making therapy an involved task. For example, I once treated a six-year-old boy who had been viciously attacked by a dog at age three. He had never been toilet trained up to the time of treatment, and appeared fixated with regard to toileting issues.

When treating children who are traumatized by a death in the family, it is important to understand that their age affects their ability to understand. Children under seven or eight have no clear conception of death, but react to the cues of the adults around them. Examples of children's perceptions about death that were witnessed on TV coverage of 9/11 are cited by Nancy Boyd Webb:

1. A 4-year-old saw a plane hit the tower and later asked her mother why the plane flew into the building.
2. Other young children saw people jump from windows and asked if there was a trampoline to catch them.
3. A 10-year-old feared a terrorist would crash into her building and kill her.
4. A 16-year-old honor student saw no point in studying—"We'll all be dead in a war or by anthrax."

(Adapted from Webb 2004, p.26, with permission from Guilford Press)

When trauma has not been processed in some way, verbally or nonverbally, negative behaviors often ensue. As noted earlier, drawing, drama, psychodrama, music, puppetry, sand, and storytelling, among other activities, may serve as ways for trauma victims to communicate their feelings.

This book has been written to help practitioners expand their use of various methods to help trauma survivors. It goes without saying that some

of these techniques require additional study; however, many can be used by therapists of all orientations in their work with trauma.

Of major importance is Dr. Crenshaw's opening chapter on the neurobioiological effects of trauma, an area that we are just now beginning to understand, followed by Dr. Nancy Boyd Webb's chapter discussing the different types of trauma and suggesting techniques that are effective with children especially. These are followed by chapters that are devoted to helping trauma survivors, child or adult, using expressive, creative arts methods such as art, drama, music, puppetry, storytelling, sand, and video. Some chapters cite work with the individual child or adult, while others use some techniques with groups and others with families. This book presents a rich assortment of very experienced practitioners who have willingly offered their talents to this important undertaking.

Note

The names of all people in the case examples have been changed for confidentiality.

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Chapter 1

Neuroscience and Trauma Treatment
Implications for Creative Arts Therapists

David Crenshaw

Neurobiological findings pertaining to trauma

Overview

The revolution in neuroscience research spurred by powerful neuroimaging techniques and biochemical advances has led to elucidation of the biological effects of psychological trauma (Solomon and Heide 2005). Among the important new understandings emerging from neuroscience research are: psychological trauma disrupts homeostasis and can cause both acute and chronic effects on many organs and biological systems (Solomon and Heide 2005); trauma exposure influences what children anticipate, focus on, and the manner in which they organize the way they appraise and process information (van der Kolk 2003a); the disruptive effects of trauma shape threat perception as expressed in thinking, feeling, behavior, and regulation of biological systems (van der Kolk 2003a); the neurobiology of secure attachment is a function of the primary caregiver's psychobiological regulation of the baby's maturing limbic system, the brain areas that specialize in adaptation to a rapidly changing environment (Schore 2001a). Additional important findings informing trauma treatment for therapists of all professional backgrounds point to the infant's early developing right hemisphere that has deep connections to the limbic and autonomic nervous systems and plays a dominant role in the human stress response (Shore 2001a).

Attachment and the right hemisphere

A secure attachment with the primary caregiver facilitates the development of the child's coping capacities (Schore 2001a). Schore (2001a) has been in the forefront of research establishing that efficient right-brain function is crucial to adaptive infant mental health, defined as the early expression of

flexible coping strategies for dealing with novelty and stress. Furthermore, Schore (2001a) has noted that efficient right-brain function is a resilience factor for optimal development throughout the life cycle.

Conversely, Schore (2001b) has demonstrated that trauma attachment, typically leading to disorganized or disoriented attachment patterns, is associated with inefficient right-brain regulatory functions and predictive of both maladaptive infant and adult mental health. In other words, early relational trauma can lead to enduring right-hemisphere inefficient function, and most alarming is the effect on the right brain's stress coping systems. The research of Schore (2001a, 200lb, 2004), van der Kolk (2003a), Perry and Pate (1994), Perry and Pollard (1998), Teicher *et al.*, (2002) among others, has demonstrated that adaptive brain development is experience-dependent; a favorable, facilitating environment is needed in order for optimal brain functioning to be achieved.

Schore (2004) has offered interdisciplinary evidence that severe relational trauma, especially neglect and/or abuse, disrupts the development of, specifically, the right brain, the biological underpinning of the unconscious. Schore (2004) argues that attachment trauma combined with an unfavorable ongoing interpersonal environment results in developmental failure of the experience-dependent maturation of the right-lateralized emotional brain.

Effects of experience on brain development

The devastating impact of severe trauma on young children has been clearly demonstrated by Perry and Pate (1994), Perry *et al.* (1995), and Perry and Pollard (1998). The young developing brain is very malleable, so early traumatic experiences can shape the developing core neurobiology of the child. While hyperarousal and dissociation are adaptive responses to trauma, continued reactivation of these adaptive responses can cause sensitization, exaggerated reactions, and perceptual distortions, and the child can become frozen in a perpetual state of low-level fear (Perry 2005).

Chronic alarm state neurobiology

In studying the neurobiological sequelae of childhood trauma, findings have suggested altered functioning of brain-stem catecholaminergic systems in childhood post-traumatic stress disorder (PTSD) (Perry and Pate 1994). Perry hypothesized that abnormal patterns of catecholamine activity were associated with prolonged alarm reactions induced by traumatic events during infancy and childhood.

Perry and Pollard (1998) observe that all experiences change the brain, but the impact is not the same for all experiences. Emotionally laden, threatening, and dangerous situations, and particularly trauma, will disrupt homeostasis in multiple areas of the brain that are called on to respond to the threat. Perry and Pollard (1998) note that since the brain is developing and organizing at an explosive rate in the early years of life, experiences during this period have more potential to influence the shaping of brain organization in both positive and detrimental ways. Chronic exposure to threat, danger, and violence can lead to the persistence of fear-related if not terror-related neurophysiologic patterns that impact emotional, behavioral, cognitive and social functioning (Perry and Pollard 1998).

Neurobiological effects of early trauma

Recent findings have pointed to the cascade of events with the potential to alter brain development as a consequence of early severe stress and maltreatment (Teicher *et al.* 2002; DeBellis *et al.* 1999a, 1999b). The stress response system is of crucial importance to all living beings; it enables the efficient and adaptive response to threat and danger. If, however, a person, and particularly a young child, who is more vulnerable due to emerging development, is exposed to extreme or long-lasting stress, alterations in the neural circuits and biologic systems involved in response to stress are likely to take place. Issues of great consequence would be timing, intensity, age of the child at the time of trauma exposure, and duration of the stress, as well as any genetic or biologic vulnerability to stress in the first place.

Implications of findings for creative arts therapists in trauma work

Streeck-Fischer and van der Kolk (2000) reviewed neurobiological research as it pertains to trauma treatment. In summarizing this research, they identified the following issues as essential to address in trauma treatment:

1. safety
2. stabilizing impulsive aggression against self and others
3. affect regulation
4. promoting mastery experiences
5. compensating for specific developmental deficits

6. judiciously processing both the traumatic memories and trauma-related expectations.

More recently van der Kolk (2003a), in discussing the tasks of therapy with traumatic children, suggested in addition to those tasks listed above the following:

7. developing an awareness of who they are and what has happened to them; this task is referred to in this chapter as repair of the sense of self
8. learning to observe what is happening in the present time and to physically respond to current demands instead of recreating the traumatic past behaviorally, emotionally, and biologically. The latter process he has sometimes referred to as desomatizing memory.

Two other goals of trauma treatment have been added in this chapter:

9. teaching self-soothing to cope with hyperaroused physiological systems
10. finding meaning, developing perspective, and a positive orientation to the future.

The essential role of the creative arts therapist

Perhaps the most notable, but also the most controversial implication of van der Kolk's work is his embracing of newer therapies that depend more on action than verbalization, including Eye Movement Desensitization and Reprocessing (EMDR), sensorimotor psychotherapy, somatic therapies, movement therapies, theater groups, massage, and martial arts training such as aikido (van der Kolk 2003b). His recommendation of these therapies has fomented severe criticism from some in the scientific community who insist that he does not have the data to prove efficacy of these non-traditional therapies. His embracing of these less language-reliant therapies is based on his long-standing belief, spelled out in his often cited paper "The body keeps the score" (1994), that the effects of trauma are often stored in body memories and that verbal therapies can't release the trauma victim from this condition.

THE LIMITS OF TALK

Van der Kolk (2003b) makes clear that he believes talking through the trauma experience is important. He explains that talk is relevant, and, in fact,

essential for traumatized patients who don't really know what happened to them, who were too young to understand what happened, whom no one listened to or believed, or who need help in making sense of what happened (2003b). Even though he describes his own therapy as still very verbal, he maintains that words can't integrate the disorganized sensations and actions that have become stuck (2003b). Van der Kolk explains how neuroimaging scans have shown that when people remember a traumatic event, the left frontal cortex shuts down—in particular the Broca's area, the center of speech and language. In contrast, the areas of the right hemisphere associated with emotional states and autonomic arousal, especially the amygdala, which is the center for detecting threat, light up. These neuroimaging techniques reveal that when people are recounting traumatic events, the frontal lobes become impaired, and consequently, they have trouble thinking and speaking.

AN INTEGRATED APPROACH TO HEALING—"ONE SIZE DOES NOT FIT ALL"

Although van der Kolk's recommendations remain controversial in the scientific community, he validates what many seasoned clinicians have recognized for a long time: that creative arts therapies, whether sandplay therapy, art, drama, music, somatic or dance therapies, massage, yoga, and the martial arts offer considerable benefit to clients who have not fully benefited from traditional verbal therapies. It seems consistent with a holistic approach, an appreciation of mind–body integration, that these therapies would have a legitimate place in the treatment of mental health disorders, and may occupy an essential role in the treatment of trauma. At the same time, it is important for clinicians to stay open to both sides of the controversy and debate, and to recognize that many of the non-traditional therapies have not met the scientific community's rigorous standards for empirically supported therapies.

Tasks of trauma therapy

CREATING SAFETY

Nothing is more essential in the treatment of trauma survivors than creating safety in the therapeutic relationship and the therapy context. Leston Havens (1989) states therapy must begin in a "safe place." James (1989) states that if a person has been terrorized, then a sense of personal control becomes essential. Recent work by Porges (2004) suggests that when human beings are frightened, they are dependent upon primitive neural circuits that reflexively organize mobilization or immobilization behaviors. When *neuroception*

(the name he uses for primitive neural circuits distinguishing whether situations are safe or dangerous) determines that the environment is safe and that the people in the situation are trustworthy, this primitive threat defense system is disabled, and then we behave in ways that encourage social engagement and positive attachment.

TEACHING SELF-SOOTHING TO DEAL WITH HYPERAROUSAL

Imagine trying to absorb new math concepts in school while at the same time constantly scanning the environment for signs of threat and danger. Children and adults in chronically violent homes commonly arrive in the therapist's office in a hyperaroused physiological state that precludes efficient processing or communication until the therapist can help the child achieve a sense of inner calm. Often these sessions will begin with soothing and calming activities, such as the therapist and child or adult doing breathing and relaxation exercises together, doing guided imagery of calming and peaceful scenes, or with an adolescent, listening together to music that the adolescent has selected as having a soothing and a calming effect (Crenshaw 2004; Crenshaw and Mordock 2005a, 2005b).

(a) Approaches to dissociation

In the case of dissociation, Gil (1991) advises that it is helpful to give the experience a name that the child or adult is able to relate to, such as "zoning out" or "spacing out." In addition, Gil recommends that the therapist engage the child (or adult) in dialogue about when it is helpful and when it is not useful to "zone or space out." The adaptational value of dissociation is that it supports survival in the face of terrifying, catastrophic events (Panzer and Viljoen 2004). The disadvantage, as Panzer and Viljoen (2004) point out, is that when dissociation occurs too frequently, the development of neural networks is impaired. Gil's approach honors the adaptive value that dissociation serves for trauma survivors but also helps them to be more mindful of when it is helpful and when it is a liability.

(b) Sensitivity to trauma's effects on cognitive processing

Children raised in violent, unsafe environments will not process, store, and retrieve information in the same way as a child with the same level of intelligence who has grown up in a safe environment (Perry 2005). Children in chronic fear states will be less efficient in processing, storing, and retrieving verbal information from the teacher or therapist and are more likely to be

focusing on nonverbal cues—such as the teacher's or therapist's facial cues, tone of voice, mannerisms, or gestures. As Perry (2005) observes, children who are raised in a milieu of violence are taught that nonverbal information is more crucial than verbal. The chronic exposure to violence and trauma shapes the child's cognition, and so will be dominated by subcortical and limbic areas of the brain (Perry 2005, LeDoux 1998).

What makes the work of the therapist even more challenging is that the degree to which the traumatized child can process, store, and retrieve information can vary widely depending on the topic and the level of threat perceived by the child. Child therapists are familiar with children who, depending on the topic, can process information at an age-appropriate level and then suddenly break off symbolic play abruptly when the topic changes, stop talking, or begin to engage in baby talk. Their level of cognitive processing suddenly regresses to earlier levels of cognitive maturation, reasoning, and language expression.

Creative arts therapists as well as other child therapists are quite familiar with sessions with traumatized children that appear to be quite disjointed, erratic, and encompass a wide range of emotions, cognitions, and behaviors that are reflective of the emotional states activated in the course of a single session. When the child is unable to process information in a session that only a few minutes prior seemed to be well within his or her capability, the therapist should assume that some external or internal cue has triggered regressed functioning.

It is important that the therapist "downshift" at that point, to gear down in language use, establish safety, reduce expectations, and/or engage the child in calming and soothing activities to reduce anxiety. If the therapist misses the signs and continues to pursue topics that the child has signaled he is not ready to handle, she will usually regret it. The child will leave the room, or spin out of control in an aggressive manner, or withdraw or detach in such a way as to become emotionally out of reach. If the therapist persists in her insensitivity to the child's often nonverbal signals that the therapy has entered territory too dangerous to proceed further, then the therapy will cease to be a safe place.

Case example

A girl, age eight, begins to play with the family dollhouse. She places and arranges the furniture in the house in the various rooms, but when she

comes to the bathroom in the house, she abruptly moves away from the house as if startled and states in the voice of a toddler, "Me no wanna play no more!"

This is an example of what Sarnoff (1987) called a "switch moment." Anxiety was triggered by the visual reminder in the dollhouse of the bathroom where the child was sexually abused when she was three years old by her mother's boyfriend. She regressed in cognition and language expression to toddlerhood, when only a few moments before she was describing the various parts of the house with cognitive and language ability appropriate for an eight-year-old child.

If the therapist were not to downshift at this point, but rather persist with a language-based inquiry such as, "I wonder what frightened you so much when you saw the bathroom?" this could result in unfortunate consequences, such as strain on the therapeutic relationship and unnecessary acting-out or disruptive behavior on the part of the child.

Trauma therapy must be child-responsive, and cues as to a child's readiness for a more challenging level of therapy must be read with sensitivity on the part of the therapist.

STABILIZING AGGRESSIVE IMPULSES

In previous writing (Crenshaw and Hardy 2005; Crenshaw 2004; Crenshaw and Mordock 2005a, 2005b), specific techniques to promote constructive anger expression have been described. It is recognized that severely maltreated children have legitimate anger and often rage, but it is vital for them, in order to function successfully in their family, school, and social group, to learn to redirect and re-channel the anger in ways that do not further compound their difficulties.

REGULATING AFFECT

James (1989, 1994) explains that traumatized children have a "broken modulator." They tend to experience affect in an all-or-none fashion. If they feel their sadness, they fear it will overwhelm not only them, but the therapist too. They worry that if they start to cry, they will never stop. If they get angry, they fear they will destroy you and everything in their path. They have not learned how to modulate affect. The specific techniques to accomplish affect modulation with traumatized children are beyond the scope of this chapter, but for the play therapist such techniques are described in a previous writing (Crenshaw and Mordock 2005a). One technique that

overlaps with art therapy approaches is called "three-step affect modulation drawings." This strategy is an attempt to make cognitive-behavioral approaches "child-friendly" (Shelby 2004).

The drawing strategies, consisting of "The volcano speaks," "The storm clouds are gathering," "The angry monster roars," and "The dragon breathes fire," are meant to engage children around affect expression and modulation. By first expressing the degree of their anger through images such as the volcano erupting, the hurricane hitting the coast, the angry monster attacking, or the fire-breathing dragon approaching, the child can work on skills of modulation in the language of symbols, which is more familiar and comfortable for younger children. The second step of the strategy is to give voice to the volcano, angry monster, storm, or dragon and to find words to express the anger that is depicted symbolically. The third step is to engage the child in problem solving as to what the volcano, dragon, storm, or monster could use as coping strategies to modulate what could be a destructive outpouring of anger and rage.

PROMOTING MASTERY EXPERIENCES

Opportunities abound within the therapeutic relationship to identify, highlight, and reinforce strengths. In addition, mastery and competency can be fostered through therapeutic tasks and homework assignments as well as practicing through role-playing, within the session, ways of handling difficult situations that arise in the child's life. In the *Handbook of Play Therapy with Aggressive Children* (Crenshaw and Mordock 2005a) several chapters are devoted to teaching children the essential skills for successful negotiation of their social world, with special emphasis on the development of the capacity for empathy—arguably the most important of all pro-social skills.

COMPENSATING FOR SPECIFIC DEVELOPMENTAL DEFICITS

If a child misses out on essential developmental experiences, such as opportunity to develop appropriate social skills or academic skills, or has a particular deficit in motor skills, or visual-perceptual or language skills, the child can be directed to appropriate remedial services in these areas. A child may need to be enrolled in a group that emphasizes development of a wide range of social skills, or she may need work in a specific area such as assertiveness or empathy skills. The key is to tailor the remedial or corrective interventions to the specific needs of a particular child at any given point in time.

Honoring and respecting children's unique abilities and gifts may enable them to bypass or struggle through the areas that are an uphill battle for them.

JUDICIOUSLY PROCESSING BOTH THE TRAUMATIC MEMORIES AND TRAUMA-RELATED EXPECTATIONS

(a) Play Therapy Decision Grid

In keeping with the need to make trauma therapy safe, in previous writing (Crenshaw and Hardy 2005; Crenshaw and Mordock 2005a, 2005b) the Play Therapy Decision Grid has been introduced to guide child therapists to determine the appropriate level of therapy for a child at any given point in time. The Play Therapy Decision Grid has two tracks: the "coping" and the "invitational." The coping track is designed to encompass the following tasks identified by van der Kolk (2002) as crucial to trauma treatment: creating safety, stabilizing impulsive aggression, regulating affect, promoting mastery experiences, and compensating for developmental deficits. The coping track is primarily a psychoeducational approach to build a safe and trustworthy therapeutic relationship, teach coping skills, identify strengths, practice crucial pro-social skills, and develop the capacity to express and modulate affect and impulse expression.

The invitational track, by contrast, is focused on inviting the child to go as far as he can in processing and working through the trauma (James 1994). When the child becomes too anxious, or shows signs of being overwhelmed, the therapist helps him move back to safer ground. It may even require a crossover, at least temporarily, to the coping track to build coping resources further before proceeding.

(b) Developmentally sequenced approach to trauma

James (1989) reminds us that children need to do trauma work in a developmentally sequenced manner. Ideally, she suggested that those who work with traumatized children adopt a family physician practice model and see the child as needed at different points in her development as she becomes cognitively and emotionally more capable of confronting the full implications of the trauma events. This is especially true in work with severely and repeatedly traumatized children. Nothing is to be gained, and harm can surely result, by pushing a child into confronting trauma events before she has the cognitive and emotional resources to process events therapeutically.

In addition to a thorough assessment and a careful review of prior history, a therapist should look for ego-strengths and coping resources, or the lack thereof, in the way the child handles anxiety-laden material in the session. If he breaks off his play, runs out of the room, or flies into a rage, this would signal that the child's internal resources for coping with anxiety and emotionally laden material are limited. The therapist should also inquire of caregivers about the after-effects of a session in which trauma or upsetting material was the focus. If the child was disruptive at home or in school after the session or had major "meltdowns," this would need to be carefully considered and most often would suggest that the child needs to be in the coping track rather than invitational at this point in time.

(c) Issues of timing

It is crucial even when working in the invitational track of therapy that therapists do not bring up an emotionally laden topic or trauma-related issues in the last third of the session. It will almost always come to sorrow. Doing so does not leave sufficient time to process the material or the anxiety, fear, and sometimes terror and rage that such topics evoke. In fact, the last third of the session with traumatized children should involve a safe transition that re-orients the child back to his or her daily life. This can be done by accentuating here-and-now sensory experiences, such as "Let's play a game, and see how many things you can find in this room that are the color blue." Or it may be helpful for the child to talk about a recent birthday party she attended, or an upcoming camping trip she is looking forward to. This will help to pull her back to shore if she is still caught in the undertow of the powerful affects and memories that threaten to pull her further from the safety of the shore (Dolan 1991).

Timing also involves building a sufficiently strong therapeutic alliance with the child, prior to moving into the invitational track, for the child to be able to tap the strength of the therapeutic relationship while doing the trauma work. This is a domain where the therapist's countertransference issues, particularly in the case of young, inexperienced therapists, can wreak havoc. Often inexperienced therapists will feel that the therapy is not moving fast enough, or feel a need to demonstrate that they "are doing good therapy." When this happens the therapy is being driven not by the genuine needs of the child but by the therapist's need to prove adequacy (Crenshaw and Mordock 2005b). This can result in unfortunate consequences, such as frequent and unnecessary crises, and in worst case scenarios risks re-

traumatizing the child. If in doubt as to whether a coping or invitational approach is appropriate, a conservative approach is recommended. Errors of going too slow are easier to correct and risk less potential harm than going too fast and overwhelming the child. Under the latter conditions the child will not feel safe and may distrust the competence and intentions of the therapist. It is also crucial that therapists not attempt to go solo in this work, but rather seek supervision or consultation from more experienced clinicians in making these critical judgments (Crenshaw 2004).

(d) Working within the metaphor

The creative arts therapist, like the play therapist, often works within the safety created by symbolization. Considerable therapeutic work can be done within the metaphor of the play characters: in the drama or interaction between them, through the drawing, or the story told in response to the drawing, or as a result of a picture created by the child in the sandtray. A series of projective drawings and storytelling strategies has been developed to engage even the most anxious and resistant child in therapy (Crenshaw 2004). Drama, music, dance, movement, and body therapies can all work in the realm of symbol and metaphor, with no direct attention or focus as to how this directly relates to the child or adult when such direct interpretation would be too threatening for her to entertain.

The power of symbol to evoke images for healing is the common thread that runs through all creative arts therapies, along with its diminished reliance on verbalization. Music, dance, and drama can evoke feelings that traumatized children would find difficult, if not impossible, to access directly by verbal means, and likewise the capacity for soothing and calming that these modalities can offer is also quite beneficial to the disquieted spirit of many traumatized children and adults.

After the events of 9/11, Landy (2002) noted that the formal structure of art work facilitates the restoration of balance to an inner world scarred by violence and terrorism. The benefits of structured writing assignments with families coping with legacies of extreme trauma have also been delineated (Lange 1996). Sometimes the symbolic expressions of trauma occur spontaneously outside of the formal therapeutic context, as observed in graffiti as a creative means of youth coping with collective trauma in Israel after the assassination of Prime Minister Y. Rabin (Klingman, Shalev, and Pearlman 2000). Additional examples of creative arts therapy with trauma survivors are described by Meekums (1999) with adult survivors of child sexual abuse;

Miller and Boe (1990) with child physical abuse victims; St. Thomas and Johnson (2002) with children of unspeakable loss; and Johnson (1987) with Vietnam veterans suffering from post-traumatic stress disorder (PTSD).

Klorer (2000) describes art therapy techniques with abused children at different developmental levels. Klorer delineates a variety of nonverbal treatment modalities including movement, sand, and dramatic play, in addition to drawing techniques. By working through the safe haven of metaphor the therapist can maintain the safe distance that the child or adult needs from direct confrontation of traumatic material until he shows signs of readiness for the invitational track of therapy and can gradually move closer to directly confronting these events.

(e) Dealing with expectations of trauma

Once the protective shield is shattered by childhood trauma, whether by an earthquake, hurricane, or other natural disaster, the child or adult lives in a state of anticipatory anxiety, waiting for the next shattering event. Even more devastating are the effects of human-made disasters such as exposure to violence, or the physical and/or sexual abuse of a child. Many adults experienced this after the horror of 9/11. It was quite common in the period immediately following this horrendous tragedy for people to get in their cars and immediately tune their radio to a news station to see if anything else had been blown up. It took several months before many adults returned to their habit of just turning on their favorite music station when starting their cars.

It is even more shattering for young children in the aftermath of trauma because they do not have the more advanced and sophisticated coping and internal psychological resources that adults typically do. Restoration of trust and a sense of safety will develop gradually, and can begin in the healing context created by the therapeutic relationship.

DESOMATIZING THE TRAUMATIC MEMORIES VIA THERAPEUTIC SYMBOLIZATION

Van der Kolk (2003a) in his recent work has emphasized that physical helplessness is at the core of trauma, and that the inability to take effective action under the immobilizing emotions of the trauma conditions plays a role in development of long-term PTSD. Van der Kolk (2003b) has referred to this as "frozen inaction." Furthermore, he has argued that meaningful, physical action may be a prerequisite for recovery from PTSD. According to this view, the trauma survivor needs to be empowered to take effective physical action

that was originally blocked due to the terrifying, immobilizing circumstances of the trauma events.

Although van der Kolk has been heavily criticized for embracing somatic therapies, it nevertheless resonates with the experience of many child therapists, who have witnessed children engaging in symbolic play and re-enacting barely disguised trauma events in a manner that empowers them to take effective action that was not possible at the time of the original events. A child who was raped may enact the rape and beating scene with puppets but then push the attacker away, or cry out for help, or call the police, leading to the arrest of the rapist. These are empowering and corrective actions that the child can enact in a symbolic realm, thereby overcoming the physiologically frozen state that has persisted long after the events have passed.

Case example

A child who was sexually assaulted goes to the dentist and when the protective apron is placed around her to protect her from radiation from the X-ray machine, she screams, throws the apron aside and runs from the office, crying hysterically. Once home, she goes to bed and pulls the covers over her and shakes and has tremors for hours afterwards. This is a dramatic example of how the body keeps the score: the heavy weight of the protective apron triggered the sensations of the heavy man on top of her while sexually assaulting her. She experienced the original terror of that event as if it were happening in the present moment. In play therapy she enacts the scene with animal puppets. The dog puppet who was a good friend of the bunny rabbit who was being attacked, jumps out from behind the building and hits the alligator assailant puppet over the head with a skillet, knocking him out cold and allowing her to escape with her friend.

The child clearly found this corrective enactment to be very empowering, and she played out many variations of this theme before it began to lose its interest for her. The child and her mother later reported that she no longer had any interest in talking about the trauma, no longer had nightmares, and there had been no signs in the past two years of the activation of body memories of the trauma.

REPAIRING THE SENSE OF SELF

Van der Kolk (2003a) observes that trauma treatment needs to help survivors become aware of who they are and what has happened to them. A crucial feature of this phase of the work is helping the child or adult to develop a sense of identity that is based on a broad vision of self and his place in the world and which does not allow the trauma events to define his sense of self. It is vital that the trauma survivor not crystallize a sense of identity that is organized around his trauma experiences. There are many ways that creative arts therapists can assist this process by helping clients to view themselves in a more complex way that takes into account their unique talents and special qualities, their inner strength, courage, determination, fighting spirit, and other inspiring traits. Qualities such as a warm smile, a good sense of humor, interests or talents in art, music, drama, sports, reading, writing, or math can be highlighted. These are traits that emanate from within the person. The abuse or violence was situational and imposed on the person forcefully and need not define who he is.

This goal can also be facilitated by putting the trauma events in an overall life-cycle perspective by drawing a timeline that encompasses the expected lifespan of the person and then highlighting the time period in which the trauma events occurred as a small segment of the overall lifespan. This can be emphasized further by using the timeline to mark positive life events, achievements, affirming experiences, and experiences of giving and helping others. This way of visually creating complexity and diversity in the life of a client will help her avoid the tendency to view herself strictly as trauma-bound. Opportunities to create this more balanced and complex view of self abound in creative arts therapy and may include drawings, paintings, dramatic creations, collages, dance, or music selections that metaphorically represent the many facets and assets of the child or adult.

FACILITATING HOPE AND PERSPECTIVE

Children and adults who have suffered the devastating impact of trauma, and in some cases repeated trauma, experience extreme disillusionment, shattered dreams, and punctured hopes. It is the goal of trauma therapists to help them pick up the pieces and to gradually shape new dreams, hopes, aspirations, and plans for the future. At first, they might not be able to do it. Hope can be a dangerous state of mind if you have been exposed to repeated disasters. It seems safer under those calamitous conditions to keep expectations low and not look beyond today.

One of the most delicate of all therapeutic operations is facilitating hope without leaving the person feeling that you have trivialized his despair, hopelessness, pain, sorrow, or trauma. Perhaps no other therapeutic intervention is so dependent on timing, sensitivity, empathy, and skill than the therapeutic response that honors the depths of the person's suffering while at the same time introducing the possibility of hope and change.

Children and adults can be asked to draw or make a collage of "A positive future," when all the suffering and problems they are struggling with now are in the past (Dolan 1991). They can be asked "What would that future look like? What would you be doing? How old will you be at that point? Who would you want to have in your life at that time? Where would you be living?" Drama therapists may be able to do dramatic enactments of such a vision of the future. While some adults and children may not be able to envision a positive future, given the bombardment of the devastating events of the past, even small steps toward such a vision is an encouraging sign.

The art of working with children and adults who have experienced trauma to find positive meaning in their life struggles is a major component of healing. Correcting the faulty cognitions of self-blame, distortions to their sense of self, and helping them to find a coherent perspective on the events of their lives is vital to creating a foundation for new possibilities in life. Helping them construct new meaning may involve respecting and honoring the spiritual or religious beliefs of the child, adult, and family, or helping them to connect their adversities in life to their strength, resilience, and capacities for survival.

The inner strength that enables them to survive is to be celebrated. May we always retain our awe and respect for the determination of the human spirit to survive even under the most heartrending and devastating of human circumstances.

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Chapter 2

Crisis Intervention Play Therapy to Help Traumatized Children

Nancy Boyd Webb

Children living in the twenty-first century can be traumatized by any number of experiences stemming from a variety of tragic events. In recent years natural disasters such as earthquakes, hurricanes, and tsunamis have killed thousands of people and left countless survivors homeless. Of course, these types of crises, often referred to as "acts of God," are not unique to our time, but because of the extensive media coverage today everyone learns about mass traumas even when they occur in remote parts of the world, making it seem as if these tragic events happen frequently.

Natural disasters strike without warning and seemingly at random, in contrast to attacks by terrorists such as occurred in the United States on 11 September 2001, in Madrid on 11 March 2004, and in London on 7 July 2005 that were planned deliberately to destroy buildings and transportation lines, while killing as many people as possible. Children whose parents or other loved ones perished during these traumatic events suffered intense emotional pain associated with the loss of an irreplaceable attachment figure. Losses such as these generate extreme anxiety about how survival will be possible without the security and comfort of the beloved persons considered essential to physical safety and psychological well-being. Indeed, child victims and survivors of mass traumas struggle to cope with what appears to them as the total upheaval of their present and future lives.

Still other forms of trauma may befall children in their own homes and communities. Instances of domestic violence and child abuse do not receive the widespread publicity of disasters and terrorist attacks, yet their occurrence can seriously impact young children who may be either witnesses or direct victims of abuse perpetrated by a family member. Some children also

witness and experience violence in their schools or neighborhoods. The distressing, indisputable truth is that children can be traumatized in any place, at any time, by persons, by accidents, or by natural events.

This chapter discusses the rationale for using play therapy to help traumatized children. A specific play therapy approach appropriate for use in trauma therapy will be discussed and two clinical vignettes will be presented. These case examples demonstrate the effectiveness of play therapy with a young refugee who witnessed the violent rape of his mother, and with another child who developed symptoms of post-traumatic stress disorder (PTSD) following the sudden death of her friend in a car accident. The chapter concludes with some guidelines for conducting crisis intervention play therapy and emphasizes the importance of obtaining specialized training in order to do this difficult and very important therapeutic work.

Trauma/crisis and children's typical responses

Trauma and crisis

The word *trauma* comes from the Greek, meaning "wound." In current usage, trauma refers to emotional, psychological, and physical injuries that cause pain and suffering. Examples of situations that may prove to be traumatic include experiences of physical or sexual abuse, the witnessing of familial or community violence, and the experience of war or terrorism. Traumatic or crisis events may include the extensive destruction of property, and the mutilating deaths of people close to the scene. Because emotions typically run rampant among those involved, children can become terrified through witnessing adults in states of panic, high arousal, or frozen shock. We know that children are particularly sensitive to the emotional climate around them and they may exhibit calm or panic, depending on the reactions and the behavior of influential adults such as parents and teachers (Arroyo and Eth 1996; McFarlane 1987). However, this is only one factor determining children's responses, since children do show post-traumatic reactions independent of their parents (Shelby 1997).

In contrast to single incident traumatic events such as natural disasters, referred to as Type I traumas (Terr 1991), other types of traumatic experiences involve repeated experiences of abuse in which the child may come to anticipate recurrence at certain times, such as when her parents drink alcohol and begin to argue (Type II traumas, Terr 1991). Whether the crisis experience is anticipated or unexpected, however, the child's usual reaction is one of helplessness and desperation because of her inability to do anything to

avoid or prevent it. Loss is always part of trauma, whether in the symbolic form of loss of a sense of safety and security, or in the form of a specific loss, such as that of a loved person, a familiar neighborhood or one's home (Webb 2004).

Similarities and distinctions between trauma and crisis

The definition of "crisis" is very similar to that of trauma. Both involve the perception of stress overload in which the person feels a sense of helplessness. Specifically, "crisis" refers to a situation which appears to exceed an individual's coping ability and leads to severe affective, cognitive, and behavioral malfunctioning (James and Gilliland 2004). This is very similar to the criteria for a traumatic event in the diagnosis of post-traumatic stress disorder (American Psychiatric Association 2000). An important distinction between the two is that crisis situations may or may not lead to subsequent symptom formation (Webb 1999). Individuals have different levels of stress tolerance, and we know that most people who experience traumatic events do not later develop post-traumatic stress responses, as will be discussed below. Nonetheless, the practice of crisis intervention rests on the belief that timely short-term intervention soon after a crisis or traumatic event may prevent the future development of psychiatric symptoms (James and Gilliland 2004; Parad and Parad 1990; Shelby 1997; Webb 1999).

Children's typical responses to traumatic and crisis events

Children can be exposed to all types of crisis and traumatic experiences, and their responses will vary, depending on such factors as their history and temperament, in addition to the nature of the stressful event itself and the extent of support offered by their helping networks. In several earlier publications I presented a tripartite assessment model using three groups of factors as an assessment tool for evaluating a child's unique understanding and response to a crisis or traumatic experience (Webb 1999, 2002, 2004). The specific groups are:

- factors related to the individual child
- factors related to the support system
- factors related to the nature of the traumatic or crisis event.

Space does not permit full discussion of this here and readers who wish more detailed information about using this assessment tool should consult *Play*

Therapy with Children in Crisis (Webb 1999) and *Mass Trauma and Violence: Helping Families and Children Cope* (Webb 2004).

As mentioned previously, traumatic experiences may or may not result in disabling traumatic grief for children or for adults. Arroyo and Eth (1996, p.54) stated, "It is impossible to predict exactly who will develop psychic trauma." Common sense, however, suggests that repeated experiences of loss and death deplete a person's ability to cope with the associated pain and anguish. Therefore therapists should take note of past losses in the child's life when making an assessment of the child's current reactions. Other relevant factors include the nature of the child's temperament and what meaning the family attributes to this particular traumatic event. For example, a child in a family that maintains that it will find a way to cope with the loss of one of its members probably will respond and adapt differently than will a child in a family that says repeatedly and morosely that "things will *never* be the same."

Several research studies (Werner and Smith 1982; Wertlieb *et al.* 1987) have found that temperament plays an important role in how the child responds to situations of extreme stress. In a recent study, anxious children were found more likely to develop PTSD, even when their exposure to a disaster was relatively low (La Greca *et al.* 1996). Similarly, young people who had shown high levels of depression and stress symptoms before an earthquake in California had even higher levels of these symptoms after the disaster (Silverman and La Greca 2002).

Post-traumatic stress disorder and other reactions to traumatic/crisis events

As already discussed, we know that all persons exposed to crisis events do not develop traumatic symptoms, and those who do may recover spontaneously after a period of time (Brady 2001; McFarlane and Yehuda 1996; Shalev 1996). Fletcher (1996) has prepared a table of incidence rates of post-traumatic stress responses and other associated symptoms and diagnoses among children and adults who were exposed to traumatic events. Using this and other reports in the literature, this section discusses the diagnoses of acute stress disorder (ASD), and post-traumatic stress disorder (PTSD), together with other diagnoses that may develop following situations of mass trauma and ongoing anxiety. It is important to recognize that symptoms from several different diagnostic clusters may exist together (referred to as "psychiatric co-morbidity") and that children may have some,

but not enough symptoms to qualify fully for a particular diagnosis (Drake, Bush, and van Gorp 2001; Gurwitch, Sullivan, and Long 1998).

Furthermore, many child therapists believe that children's specific responses to traumatic events are inadequately represented in the *Diagnostic and Statistical Manual* (American Psychiatric Association 2000), possibly because of children's limited verbal abilities and/or their unwillingness to revisit or reveal their frightening memories (McFarlane 1987; Scheeringa and Zenah 2001; Shelby 1997). This is why play therapy is so useful, since it permits the child to deal with his anxieties symbolically without open acknowledgement of his own frightening experience.

A diagnosis of PTSD requires the presence of specific clusters of symptoms that follow the experience of the frightening traumatic event (American Psychiatric Association 2000). The nature of these symptomatic reactions involves responses that have been characterized as re-experiencing, avoidance and numbing, and arousal.

Re-experiencing often takes the form of nightmares in children. These may or may not contain specific content resembling the traumatic experience. Children sometimes also keep remembering the traumatic event, as in the case of Sergio, discussed at the end of this chapter, who referred to "bad thoughts" about his terrifying escape to the United States.

Avoidance is a typical defensive response that protects the individual from recalling the frightening details of a traumatic experience. Children (and adults) often do not want to discuss their frightening memories and they may try to avoid situations that remind them of the experience. The case of Susan, discussed at the end of this chapter, demonstrates a child's panicked avoidant response when her mother drove her near the home of her recently traumatically deceased friend.

Hyper-vigilance is a form of *arousal* reaction that keeps the person on the alert and jumpy because of the fearful expectation of additional traumatic occurrences. For example, a child living in a war zone will deliberately be attentive to sounds that signal a potential attack, while also deliberately pushing away thoughts about the dangerous situation in order to concentrate on his homework and be able to fall asleep at night (Webb 2004). These contradictory realities create a climate of ongoing stress that leaves the child feeling on edge and fearful.

The diagnosis of PTSD requires that symptoms be present for at least four weeks, which may be an unrealistic time-frame for children who tend to respond sooner rather than later (Shelby 1997). Even when children qualify

for this diagnosis, the symptoms may remit in time. McFarlane and Yehuda (1996) state that:

> The typical pattern for even the most catastrophic experiences is resolution of symptoms and not the development of PTSD. Only a minority of the victims will go on to develop PTSD, and with the passage of time the symptoms will resolve in approximately two thirds of these. (p.156)

This statement argues for the necessity for rigorous research to study the efficacy of different treatment approaches following crisis and traumatic events. We need to know how best to help the approximate one third of persons whose symptoms do *not* resolve spontaneously. The present chapter, while not empirically based, proposes that crisis intervention play therapy can be helpful in reducing or eliminating distressing symptoms related to a traumatic experience.

The diagnosis of acute stress disorder is used when symptoms similar to PTSD occur *prior to* the one-month time requirement. ASD actually includes most of the same criteria as PTSD, with the addition of symptoms of dissociation. Dissociative disorders are rarely diagnosed in children, except for sexually and physically abused children (Wolfe and Birt 1997).

In addition to the symptoms associated with ASD and PTSD, a variety of other symptoms and reactions are common in children following traumatic events. These include anxiety and fear, depression, regressive behavior, somatic complaints, and other problem behaviors such as sleep disorders (Gurwitch *et al.* 1998). Anxiety reactions take the form of separation anxiety and specific fears in situations that generate reminders of the actual traumatic event. The physical separations that often occur in the aftermath of traumas can be particularly frightening to children and contribute to anxiety reactions. In addition, high rates of depression often accompany chronic PTSD among children and adolescents (Goenjian *et al.* 1995). When their responses cause drastic behavior changes that interfere with their usual ability to carry out their school and other activities, children may be referred to a mental health clinic or a private practitioner for help. Play therapy is appropriate for all children, and when a traumatic or crisis event has been a precipitating factor in the child's problematic behavior, crisis intervention play therapy is the treatment of choice.

The rationale for using play therapy with traumatized children

Play therapy has evolved since the 1920s as the preferred method for helping children to resolve their emotional conflicts. Because of their limited verbal ability children tend to "play out" their problems, just as adults talk about theirs. Therapists have learned how to communicate and provide therapy for children using a variety of play techniques. Play has been referred to as the "language of childhood," with toys as the equivalent of words in this language. As I stated in a previous publication (Webb 1999, p.29), "Play therapy ingeniously undertakes the hard work of child psychotherapy in the appealing guise of play."

Different child therapists subscribe to different theoretical orientations, such as gestalt, cognitive-behavioral, Jungian, crisis intervention, developmental, and psychoanalytic/psychodynamic. Schaefer (2003) presents 14 different models of play therapy and his list is not exhaustive. The therapist's training and particular theoretical perspective affect his or her specific views about the nature of human behavior and how it can change, as well as about how to assist individuals who are having problems. Regardless of the theoretical orientation of the therapist, however, all child therapy approaches emphasize the power of the therapeutic relationship as the source of healing. Therefore all play therapists attempt to convey acceptance and respect for the child's individuality, together with a sincere empathic attitude of wanting to help and a commitment to do so.

On the other hand, the different orientations diverge about precisely how the therapist will carry out the helping role, especially regarding the degree to which it is considered appropriate to attempt to direct the child and make suggestions about engaging in a particular drawing or play activity. For example, the therapist using a child-centered play therapy approach (Landreth 2002) will refrain from making *any* suggestions to the child, whereas a therapist with a cognitive-behavioral play therapy orientation (Knell 2003) usually provides very specific directions to the child during the therapy sessions. These suggestions are often based on knowledge about the child from parents and teachers, rather than from observations of the child in play therapy sessions.

The actual play materials used in therapy include a variety of drawing and plastic materials, bendable family dolls, a selection of puppets, toy cars, trucks, and rescue vehicles, blocks, medical kits, card and board games, sandtrays and miniature figures, magic wands, toy telephones, musical

instruments, and virtually anything that the therapist believes will assist the child in expressing his feelings. The play materials are considered as catalysts and stimuli onto which the child projects and displaces his conflicts and anxieties.

Sometimes play therapy is conducted with families (Schaefer and Carey 1994), other times with small groups (Sweeney 2003; Sweeney and Homeyer 1999), and most commonly on a one-to-one basis. The examples in this chapter demonstrate individual play therapy.

Crisis intervention play therapy

This short-term approach incorporates elements of cognitive-behavioral play therapy and psychodynamic play therapy. Numerous anecdotal reports attest to the treatment effectiveness of crisis intervention play therapy in helping traumatized children (Brohl 1996; Shelby 1997; Webb 1999, 2004).

Psychodynamic play therapy is a long-term model, in comparison to crisis intervention and cognitive-behavioral approaches. The psychodynamic play therapist understands the child's play in symbolic terms as the projection of the child's inner feelings onto the play materials. The child works to obtain mastery (in symbolic play) over her past overwhelming experiences; play provides a sort of camouflage and the distance necessary for psychological safety (Bromfield 2003). Of course, the whole field of play therapy rests on the assumption that the child uses play materials on which to project her inner world. Therefore the profession owes a great theoretical debt to the pioneer work of the early child analysts Melanie Klein (1975) and Anna Freud (1974), who were among the first to use play with children in therapy.

Cognitive-behavioral play therapy also emphasizes the importance of a positive therapeutic relationship and the use of play as the means of communication with a child in therapy. However, the role of the cognitive-behavioral therapist is quite directive, based on specific goals that have been set to help the child change his or her thinking, perceptions, and problematic behavior (Knell 2003). An underlying premise of cognitive-behavioral therapy is that thoughts influence feelings, so if the therapist can help the individual toward a different understanding of the situation, this changed perception will alleviate feelings of distress. Often young children, who are normally egocentric, think that problem situations occurred because of something they did or did not do. The cognitive-behavioral play therapist will attempt to repair such faulty thinking by using toys such as puppets to

act out a situation similar to that of the child's, and then model a more accurate and less personally detrimental outcome. In this way, this approach utilizes education and modeling to change a child's perceptions and teach more adaptive coping skills.

The *crisis intervention* play therapist also attempts to repair a child's faulty perceptions and often offers information to clarify any incorrect attributions related to the cause of a crisis or traumatic event. The crisis intervention therapist may provide specific toys suggestive of the child's traumatic experience and encourage the child to play this out using the toys. For example, when I was treating a six-year-old boy whose father, a volunteer fireman, had died in a house fire, I purposely placed several toy firemen figures and fire engines where the boy could easily find them during his play therapy session. Although he did not play with them in the first few sessions, several weeks later, when he felt sufficiently secure with me, he used these toys to spontaneously reconstruct his perception of the fire scene in which his father died. In this situation I deliberately waited for the child to take the lead in approaching his frightening memories.

The degree of direct suggestion given to the child depends on the therapist's judgment about the child's ability to tolerate the anxiety associated with re-enacting the traumatic event through play. Ideally, the therapist uses the early sessions with the child to build the relationship and to teach the child some relaxation exercises and some guided imagery methods for controlling anxiety. The case of Sergio (Bevin 1999), discussed below, illustrates how a sensitive therapist used relaxation exercises together with drawing and play with a traumatized child over the course of several play therapy sessions before guiding the boy to slowly recreate his frightening experience.

As already noted, traumatized children are especially fearful about talking about their past fearful experience. The premise in play therapy is that, once the child feels comfortable with the therapist, she will use the toys to symbolically play out a scene with events, emotions, and themes similar to her own experience. However, the manner in which the therapist approaches the child and invites her to participate influences the nature of the subsequent play interactions. The crisis intervention play therapist usually states directly to the child in the first session that she knows about the terrible experience the child has endured, and that her job is to help children by talking and by playing with them to reduce their worries about their frightening experiences. This basically serves as a contract, or understanding

between the child and therapist, which makes it clear to the child that her problems will be understood, either directly or indirectly, by means of play communication.

The process of reconstructing the traumatic experience, either literally or symbolically, in the play therapy, although initially frightening, eventually provides a great source of cathartic relief to the child. Whereas the memory remains threatening to the child, the crisis therapist finds ways to point out that this event occurred in the past and that the child survived and is safe and stronger now. The ultimate goal of crisis intervention play therapy is for the child to gain some feeling of mastery over the traumatic experience through the realization that it will no longer continue to impact on her life.

Clinical examples

This section presents two cases to illustrate selected methods of crisis intervention play therapy in situations of a Type I and a Type II trauma (Terr 1991). The first involves a nine-year-old girl, Susan, who was functioning well until she suffered the sudden, traumatic loss of a friend in a car accident (Type I trauma). The second case describes a series of traumatic events that occurred to a nine-year-old boy, Sergio, a refugee from Nicaragua who almost drowned while fleeing from Mexico over the Rio Grande, and who then witnessed his mother's rape, followed by their flight (Type II trauma). In both cases, the crisis intervention therapists acknowledged and empathized with the children's frightened feelings and attempted to clarify any cognitive distortions, while also emphasizing the children's good survival strategies, coping abilities, and current safety. Both of these cases have been previously published (Webb 2002; Bevin 1999) and are presented here in a summarized version to illustrate selected methods in crisis intervention play therapy.

The case of Susan, age nine

FAMILY INFORMATION

Susan, age nine, was in fourth grade and active in Girl Scouts. She was from a middle-class, Protestant family, with one younger sister. Susan's family and Carl's had been very close for many years. The mothers were intimate friends and both families attended the same church and interacted socially.

THE CRISIS EVENT

On a sunny afternoon Carl's mother picked him up at school and was driving home on a familiar road when the car went off the road and a tree branch came through the car window, piercing Carl's body, and he died on the scene. The rumor in the community and in Susan's school was that the branch had decapitated the boy. Although this was not in fact true, the rumor spread quickly and everybody at school and in the community whispered about Carl's horrible death. Only years later did Susan learn the true cause of her friend's death—namely, that the branch had pierced his stomach and he had bled to death. Susan's mother, who understandably was very upset about Carl's death, had not been able to discuss it with her daughter, and she was unaware of Susan's misperception at the time. This is an example of a rumor taking on a reality of its own that was so horrible no one could discuss it.

REASON FOR REFERRAL

Susan's behavior had changed quite drastically following Carl's death. Whereas previously she had been quite pleasant and outgoing, since the accident she had become "angry, cranky, and mean", according to her mother. She had stopped doing her homework, and instead of involving herself with friends after school Susan stayed in her room, saying she was "tired." She was also complaining of headaches and bad dreams every night that interfered with her sleep. Susan's mother was concerned that her daughter had not shed a single tear at Carl's funeral and she refused to go to his house to speak with his mother or sister. Furthermore, Susan would become agitated and panicky whenever her mother drove anywhere near Carl's neighborhood.

PLAY THERAPY SESSIONS

Although Susan had initially refused to come into my office, she did so after I went outside to greet her while she was still seated in her mother's car. In the first session I told Susan that I knew about her friend's terrible death and I explained my role as a doctor who helps kids with their troubles and worries. Susan told me about her nightmares and I empathized with her about them, saying that sometimes daytime worries come back at night in the form of bad dreams. She denied that she had any worries.

When I invited her to draw a person, Susan drew a Girl Scout surrounded by lots of lines that suggested falling debris or a tornado. In the

next session when I asked her to draw a family she drew a Girl Scout troop, all encircled by what appeared to be a spiraling whirlwind. None of the figures looked happy and both drawings conveyed a sense of vulnerability and danger. However, Susan declined my invitation to tell me anything about either picture and, because I sensed the girl's strong reluctance to admit to any conscious worries, I refrained from saying anything to make her feel defensive.

Susan moved quickly from one activity to another. She would draw rapidly and then proceed to something different. She selected the boardgame "Battleship" from my large collection of games and toys, and she wanted to play this repeatedly. She even drew a picture of the two of us playing this game. Susan's repeated choice of this game, together with her animation during the play, caused me to believe that there was something about the game that had special significance for her. Because the game consists of the sequential bombing of each player's ships until a boat eventually sinks, I realized that the underlying theme involved sudden death, not unlike that caused by a car going unpredictably off the road. Therefore, my comments during the play reflected the notion of being scared because we never know when a bomb might hit and when our boat would sink. I also expressed concern about what would happen to the people in the boats that sank. I was, of course, referring symbolically to Carl's unexpected, accidental death. Another time we participated in a squiggle story activity—we took turns making scribble drawings and then I invited Susan to find figures in the drawings, color them in, and make up a story about them. Susan's invented story also had themes of sudden death, with danger to a princess, and her eventual rescue by her father, the king. I commented at the end of Susan's story that although the princess had been close to danger, she had decided to create a peaceful ending.

After about five weeks of therapy, Susan's headaches and nightmares stopped. Even though we had not spoken very much about Carl, and not at all about the specific nature of his death, the therapy had apparently relieved Susan of some of her anxiety. In our termination session she described briefly her visit with her mother on Carl's birthday to the mausoleum where he was interred, and when I asked her to elaborate on the experience, she volunteered to draw a picture of it. She also drew a picture of a Girl Scout in response to my request that she draw a person. This time there was no tornado around the figure and the scout was smiling and cookies were included in the drawing.

DISCUSSION

The play therapy sessions presented here did not directly instruct the child to reconstruct her friend's tragic death. Nevertheless in the therapy sessions, where this girl felt safe and understood, she used symbolic play very effectively to convey her fears and anxieties in a disguised form. The therapist's role was to acknowledge in a general way frightening feelings about unexpected death, and to remark on the child's choice of positive outcomes following danger. This process seemed to bring cathartic relief and a sense of mastery through the means of metaphor. Susan was never asked to reconstruct the traumatic images of Carl's actual death scene, as she imagined it to be, but her spontaneous story of a princess who was in danger and who was finally saved from death by her father suggests a hopeful theme of rescue and survival for herself that was not true in her friend's case. Actually I worked with this girl well before the crisis and trauma field developed the concept of "trauma re-enactment." I was relying on Lenore Terr's (1989, p.14) statement that "an entire treatment through play may be engineered without stepping far beyond the metaphor of the game." Susan's presenting symptoms were resolved, and she had returned to her pre-crisis functioning. Of course, I realized that more therapeutic work would probably be needed in the future. This proved to be true a year later, when Susan returned for one session because of an "anniversary reaction" in the form of regressed behavior around the first anniversary date of Carl's death.

The next case also involves a nine-year-old. However, in contrast to Susan, this child endured multiple traumas which led to the formation of serious symptoms that were affecting his functioning at home and at school.

The case of Sergio, age nine

FAMILY INFORMATION

Sergio grew up in Nicaragua on a farm with his parents and younger sister. Because of gunfights and unrest in their neighborhood, Sergio's father left to find work in the United States, intending to send for his family later. After two years Sergio's father made arrangements for his wife to take her two children to Mexico and cross into the United States with the help of a *coyote** who was supposed to guide the family across the Rio Grande river.

* one who smuggles immigrants into the US

THE CRISIS EVENT

Sergio's mother was carrying a basket with dry clothes on her head and carrying the two-year-old child in her arms. Sergio was holding his mother's skirts as they started to cross the river. The current was very strong, and the mother lost her footing and fell to her knees; Sergio was dragged away by the current. He grabbed onto a tree branch and his mother eventually was able to rescue him. As soon as they managed to get ashore the *coyote* appeared and threatened the mother at gunpoint, and then raped her while Sergio watched helplessly in terror. The family then proceeded to a house where the father came in a few days to meet them. Sergio did not speak during the two-day period until they were reunited.

REASON FOR REFERRAL

Approximately two months after this traumatic experience Sergio was enrolled in school, in a bilingual class. He did not speak in school, did not make friends, and whenever one of his classmates tried to interact with him Sergio would drop to the floor, sobbing, and holding his head in his hands. In addition, Sergio was having trouble sleeping at night, and would get up frequently and walk around his room.

PLAY THERAPY SESSIONS

The first few sessions consisted of talking, drawing, relaxation exercises, and free play activities. The Spanish-speaking therapist told Sergio that she was someone who understood children's fears and that she wanted to help him sleep better and have a better time in school. The therapist initially refrained from presenting Sergio with any toys that might recall memories of his traumatic experiences.

At the fifth session, however, the therapist decided to introduce a toy bathtub, some small plastic doll figures and a block of wood floating in the water. She encouraged Sergio to have the figures swim in the water, which he eventually agreed to do after pouring some of the water out of the tub. Sergio created a happy scene of a family fishing with both the father and mother present.

In the next session the therapist provided the same toys and bargained with him to pretend that the water was a river that the family needed to cross. After again insisting on pouring out some of the water, and with a lot of ongoing encouragement from the therapist, Sergio eventually recreated his trauma, including the current making him feel as if he were drowning, and coughing up the dirty, bad-tasting water.

During this re-enactment Sergio began referring to his own experience (rather than projecting onto the dolls). The therapist's comments emphasized how strong he was to have endured such a terrible experience.

In the next session the therapist decided to attempt a "role-play" of the mother's rape. She provided three rag dolls (two males, and one female) and asked Sergio to show what happened after they crossed the river. Initially the boy resisted, and said it was boring to do this. However, the therapist encouraged and reassured Sergio by reminding him that he and his mother were safe now. The boy then was able to depict the attack with the dolls, mentioning the *coyote*'s gun, his angry words and threats, the struggle, and what Sergio referred to as "fighting" during the rape. The therapist focused on how Sergio had felt during this terrible experience, as well as during the following day when the family waited in a safe house until the father arrived. The threat of being reported to the immigration authorities and being sent back to Nicaragua kept the family from reporting the rape, or even telling the father about it until they had traveled far away to their new home in a different part of the county.

In the subsequent two sessions, the therapist encouraged Sergio to act out in play his retaliation fantasies toward the *coyote*. She validated his anger, and permitted him a way through play to turn the passivity and helplessness he experienced during the traumatic event into active expression of his frustration and anger. Around this time Sergio's nightmares diminished and he began to form new relationships with his peers.

DISCUSSION

This boy had suffered a series of traumatic experiences, beginning in his homeland where his family lived in a dangerous environment surrounded by gunfire. He then endured the stress involved in fleeing from his homeland without his father and then traveling through a strange country. His own near-drowning followed by witnessing his mother's rape, and her subsequent admonition not to talk about it, all resulted in a child who was multiply traumatized.

Without the steady and sensitive persuasion of a compassionate therapist who urged him to reconstruct his experience, it is most unlikely that this boy would ever have attained any degree of symptom relief. He did admit that he was having "bad thoughts" and "bad dreams," but cultural conditioning expected this boy to maintain a "macho" stance.

The process of crisis intervention therapy illustrated here demonstrates how to effectively build a relationship with a traumatized child,

and then how to gradually help him face his horrible experience, at his own pace. The therapist repeatedly emphasized the boy's strengths and resilience, and the boy gradually began integrating this into his own self-concept. The impediments to his normal developmental course had been removed through crisis intervention play therapy.

Summary and conclusions

Children who are traumatized and who have symptoms that are interfering with their normal developmental course benefit from crisis intervention play therapy that helps them relieve their anxieties and move on with their lives. This particular form of play therapy adheres to the following guidelines:

1. Establish a supportive therapeutic relationship with the child.
2. Teach the child some relaxation methods to help keep anxiety in check.
3. Provide toys that will assist the child in recreating the traumatic event.
4. Once the child feels safe in the therapeutic relationship, encourage a gradual re-enactment of the traumatic event with the toys.
5. Move at the child's pace; do not attempt too much in one session.
6. Emphasize the child's strength as a survivor.
7. Repeat that the traumatic experience was in the *past*.
8. Point out that the child is safe in the present.

This work is difficult both for the child and the therapist. Clinicians who wish to do crisis intervention play therapy should be well grounded in play therapy, in trauma therapy, and in grief counseling. All should seek ways to obtain ongoing support and supervision for themselves in order to avoid what has been termed "vicarious traumatization." This relates to the personal reactions of therapists who become traumatized themselves in the course of their work with trauma survivors.

We do know how to help traumatized children. It is most gratifying to observe the reduction of a child's symptoms, and his return to pre-crisis functioning. This work, while very challenging, is also very rewarding and well worth the struggle to overcome and cast out the demons of fear that develop after traumatic experiences.

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Chapter 3

Working Toward Aesthetic Distance
Drama Therapy for Adult Victims of Trauma

Judith Glass

Drama therapy is defined as "the intentional and systematic use of drama/theater processes to achieve psychological growth and change" (Emunah 1994, p.3). Part of the intention of drama therapy (as in many forms of psychotherapy) is to provide symptom relief. Victims of trauma experience a variety of symptoms, including intrusive memories of the traumatic event, efforts to avoid any stimuli associated with the trauma, restricted range of emotion, detachment from others, and generally increased arousal (American Psychiatric Association (APA) 2003). The above symptoms are some of the criteria for the diagnosis of post-traumatic stress disorder (PTSD), an anxiety disorder described in the *Diagnostic and Statistical Manual of Mental Disorders* published by the APA. "Behavioral and cognitive-behavioral methods that fall in the category of exposure therapy are now arguably the treatment of choice for PTSD" (Leskin and Ruzek 2003, p. 15).

Exposure therapy seeks to desensitize the trauma victim to stimuli associated with the trauma. The most common form of exposure therapy is systematic desensitization, either using imagery or in vivo experiences.

In systematic desensitization, the client is taught relaxation techniques as an antidote or competing response to anxiety. The client then images various triggering stimuli associated with the trauma from least anxiety provoking to most anxiety provoking, coming back to the relaxation techniques when the anxiety becomes unbearable. The therapist and client can also employ systematic desensitization in vivo—actually having the client go to trauma-related places with the therapist or engage in anxiety-producing activities. Thoughts which also contribute to the anxiety can be uncovered, explored, and modified, either during the process of systematic desensitization or afterward in a debriefing of the process.

In this chapter, I will demonstrate how drama therapy can be effective in preparing the trauma victim to undergo exposure therapy and how drama therapy methods can be used within exposure therapy, modifying affective, behavioral, and cognitive symptoms resulting from trauma. The drama-therapeutic concept of *aesthetic distance* will be referred to in the chapter as a touchstone for assessment of the effectiveness of treatment. Aesthetic distance is defined as the point at which the client can have access to his feelings and also maintain an observer stance. Robert Landy states: "At aesthetic distance one retains the role of the overdistanced, cognitive observer and the role of the underdistanced, affective actor" (1994, p.114).

It is my contention that in the initial phases of treatment for trauma, over-distancing techniques are most effective, particularly in establishing safety and observing ego functions, in preparation for exposure treatment. Under-distancing techniques are more effective toward the latter phases of treatment, when exposure to stimuli associated with the trauma is experienced. However, over-distancing techniques can be useful throughout treatment when the client becomes flooded with emotion, and requires more distance from affect-laden material. The goal for the client is aesthetic distance in speaking of or remembering the trauma.

Following is a brief literature review of trauma recovery work being done by drama therapists and psychodramatists, from the perspective of both preparing the client for exposure techniques and helping the trauma survivor achieve a balance or aesthetic distance from the trauma.

Bonnie Meekums (1999) uses creative arts therapies, including drama therapy, to contain and distance, particularly with the use of imagery that can be seen as separate from the self, and therefore approachable. She developed a model that grew out of doctoral research with female survivors of early sexual abuse, who participated in a group therapy process. Francesca Toscani (1998) describes using sandtray therapy in "sandrama" with a survivor of severe sexual and physical abuse from childhood. The client manipulated the sandtray figures, without embodying them, giving her the distance to eventually release emotion by talking to the objects rather than role reversing with them. James and Johnson (1996) used metaphor and method acting with veterans suffering from PTSD to help them express and modulate affect.

Robert Landy uses role theory as a theoretical backdrop for a model which attempts to unify or at least further communication among disparate parts of the self. The model is role–counterrole-guide (Landy 2003): The

client defines a part of the self as a particular *role*; another role which is the opposite of the first role is defined as a *counterrole*; finally, the client identifies a mediator between the role and counterrole, and calls this role the *guide*. All three roles are aspects of the client's self. Landy speaks of the usefulness of this method when working with individuals affected by the events of 11 September 2001. Kate Hudgins, in her model for treating trauma—the therapeutic spiral model (Hudgins 2002)—works with clients in embodying "strength" or "wisdom" figures at the onset of treatment. Hudgins also uses an intervention called "the containing double," which embodies the cognitive capacity (or wished-for cognitive capacity) of the trauma survivor in order to prevent emotional flooding and regression during treatment (Hudgins and Drucker 1998). The therapeutic value of significant attachments to roles in building a "cohesive self structure" is explored by the drama therapist Christopher Doyle in his article "A self psychology theory of role in drama therapy" (1998).

From November 1995 to April 2001, I served as the sexual trauma therapist at the Concord Veterans' Center in Concord, California. My role was to treat veterans, male and female, who had been sexually harassed or sexually assaulted during their military service. I treated these veterans in both group and individual treatment, sometimes engaging the family in treatment as well. The majority of these clients were diagnosed with PTSD. Case examples are largely from this population. However, I have also used the drama therapy techniques described in this chapter with private practice clients suffering from trauma other than sexual assault.

Case example

In a group for women veterans, one veteran role-played having dinner with her parents, who repeatedly ignored her opinions, not even acknowledging her when she spoke. As the group leader, I had her replay the scene several times. The veteran finally asserted herself, her voice clear, articulate, and calm. This behavior was mirrored back to her by another veteran in the group, who had been chosen to be in the role-play.

The protagonist or central figure in this mini-drama was a woman who had survived a rape and was not yet ready to work directly with exposure to memories of the rape. One of her troubling symptoms was fear of asserting her needs, particularly with authority figures. When she reported the rape in the military, she was treated as if she were to blame

> and transferred to a less favorable assignment (not an uncommon result of reporting sexual trauma). In this role-play, she began to develop a role in which she could assert herself—a strength which she can concretize or make tangible again and again in role when the hard work of integrating cut-off affect is approached in therapy.

One of the goals of exposure therapy is to retrieve feelings that have been shut down since the trauma occurred. Expressions of vulnerability or anger or sadness can become triggers for the memory of the trauma itself, and therefore forbidden.

Working with roles that are developed and practiced in group or individual sessions is an over-distanced approach which conveys to the trauma victim that he has other roles besides that of victim, and that he has inner resources from which to draw. Occasionally, a client refuses to think of himself in any positive roles. When this occurs, the client can be asked to embody the role of a friend, family member, ancestor, even imaginary person, who represents courage, strength, wisdom, etc. This person can be a historical figure or a character from a novel or movie. This approach is over-distanced because the trauma is not being dealt with directly, rather strengths are being developed and concretized as "oases" from which the client can draw sustenance. If the anxiety in the exposure work becomes too great, the client can be role-reversed into one of these strength roles that have already been developed within the drama therapy sessions. These roles can serve as observing egos which can help contain emotional flooding. The client can find objects that remind him or her of these strength roles and hold onto them during times of stress or when describing the trauma. These serve as talismans for what the role might represent.

A related approach to creating a sustaining, strength-giving role is enacting a nurturing, soothing place. This can be a real or an imagined place. I have had clients (in group or individual treatment) draw a place that feels "safe" to them, or magical, or soothing. From the drawing, the images are enacted. Other group members can take the roles of the elements of the nurturing place and the client can watch. A less distancing strategy is to have the client switch places with the elements or role-reverse with a particular aspect of the place. As with the role becoming a self-object (Doyle 1998), an enacted place can become a positive self-object. This can be the image that the trauma victim "returns" to as the "location of no anxiety"—the zero point on a desensitization scale when, in going through the exposure phase of the therapy, the client begins to remember parts of the trauma previously denied,

or feelings previously dissociated. I often ask the client to "anchor" the image in a part of her body. I suggest that the client visualize or actually place the image with her hand on her heart, head, or stomach (for example) so that the feeling of support can be accessed by visualizing the image and placing the hand on a particular part of the self.

Images or objects can also serve as repositories for distressing feelings or messages that attack self-esteem. The projection onto objects can be over-distanced in the treatment context of working with trauma, because the clients are able to detach themselves from the feeling or message that is overwhelming or sabotaging.

Case example

One of the female rape victims I was treating repeatedly regressed to a place inside herself where she felt like she was "no good." Messages arising from the trauma about her "being sullied" and "at fault" had turned into "inner voices" that told her she was "bad and incompetent." These negative messages were particularly virulent when the client was anxious. I asked her to concretize or make visual and tangible this inner place of "bad messages." The veteran chose a black scarf from some props in my office. Every time during a therapy session when the "I'm stupid, bad, incompetent" voice or message clicked in, the client would pick up the black scarf. She reported that in one of her classes at school, she began to feel inadequate and was having trouble paying attention. She was thinking about fleeing the class. She remembered the black scarf. She wrote "black scarf" in the margin of her notes, laughed silently to herself, mentally turned off the "bad mental tapes" and stayed in class. By concretizing the "bad" messages via an object, she was able to place the "badness" outside herself so that *she* was not the badness.

The above two clinical examples are instances of both over-distancing techniques and preparation techniques for exposure therapy. The first client used an inner resource as a strength—the role of assertive daughter; the second client looked to an object—the black scarf—outside herself to remind her that she was not her self-defeating messages.

Early on in treatment, I ask clients to bring in photographs of themselves before the trauma occurred. This can be done in a group or individually. On the spectrum of distancing techniques, this technique is a step toward under-distancing, because clients are looking not directly at themselves, but

indirectly. (Roles of wise ones and strong ones and aspects of "safe" places are really intrapsychic aspects of the self. However, they are initially externalized as "not me.") The photographs are direct representations of the client before the trauma. Initially, I will ask the client to write a letter to himself in the photograph. This is a gradual warm-up to speaking to the photograph, and then to the image in an empty chair. As the goal is for the trauma victim to become the trauma *survivor*, the work with the photographs helps process the individual's grief for what was lost or shattered by the trauma. In addressing the image of the "naïve" self, the trauma victim both embraces her injured self, assuring herself that she did and will survive, and reiterates to herself that there are parts of the pre-trauma person that still survive in her present self. Another way to work dramatically with the "before and after" of the traumatic event is through setting up (with scarves, objects, or photographs) a timeline that illustrates, clarifies, and allows the client to speak of changes since the trauma. Part of the task in this phase is expressing and containing feelings of sadness, rage, and guilt. One of the clients that I worked with brought in boxes of memorabilia from her military service. She created a timeline with these objects and was able to see clearly that she had had triumphs in this phase of her life, as well as tragedy. She was also able to identify those persons who had supported her and those who had betrayed her. She was then able to do some empty chair imagery and express her feelings to some of these individuals in a way that had been inaccessible to her before.

One of the other methods that I have used to approach the identification and expression of strong feeling is through making masks. Making a mask can begin as an over-distanced approach that identifies and symbolizes an affect state. As the mask is worked with in various role-plays, both embodied by the client and addressed as if outside the self, the expression of the feeling that the mask represents becomes less frightening to the client. The client, wearing the mask of anger (for instance), can rehearse ways of titrating that anger, depending upon the interpersonal context.

Case example

One of my clients in individual treatment drew a double-sided mask. One side of the mask was tearful, the other furious. She usually led with the tearful, passive side of herself. The mask exercise allowed for the acknowledgement of the anger underneath the depression. The drawing

> of the mask, which was a projective, over-distanced exercise with this client, developed into enactments of different parts of herself. The client could speak to the "masks" or different parts of herself, as I became her "double." As her double, or alter ego, I could support her by standing next to her and speaking what was unspoken, but revealed in her body language. As double, I always checked in with the client to ensure that the "doubling" rang true for her. I could also, as double, model expressions of anger. Through these intra-psychic enactments, the client was able to role-play speaking to significant others who did not support her in the aftermath of a rape. She was eventually able to role-play venting her fury at the perpetrator. She had been role-stuck in a depressive role. Objectifying and embodying her anger, initially through making a mask, and then eventually in structured role-plays, helped this client feel more authentic and assertive in her interactions with others. She also felt less dissociated from other parts of herself, such as her joyful self and her competent self.

In group treatment with trauma victims, I have had the participants draw masks and then take on the masks of others. This exercise promotes universality and builds empathy with one another in the group. The person embodying another's mask becomes a "double" for that individual.

The mask is a metaphor that simultaneously reveals and hides the self. In the above case illustration, embodying the "mask" of anger was empowering for the client. I have also used myths, particularly goddess myths, as "enacted metaphors" for women to develop more assertive roles. In group treatment I have worked with several goddess myths. I bring in various myths, and also encourage the women to research myths that are appealing to them. I then ask the women to group the myths according to themes, and to create collages that represent the goddesses or myths grouped together under a particular theme, such as "mother" or "nature" or "naïve." I ask the participants to find a theme that best speaks to them right now in their recovery from trauma. These subgroups create collages on the theme, and "sculptures" (using themselves or objects) representing that theme in their own lives. Then I ask volunteers to enact scenes from their current lives that could use the "help" or "energy" of a particular goddess.

Case example

One young woman was attracted to the myth of Artemis, a Greek goddess who championed women in childbirth and was known as a "protectress" of young girls. Artemis chose to remain mate-less in the traditional sense, though she traveled with a pack of dogs and a flock of nymphs. This goddess was known for her affinity for nature and her expertise as a hunter. This client felt in thrall to her dominating, abusive father, even though she was an adult and no longer lived with her parents. In an enacted scene in which the client made a telephone call to her father, she embodied the role of Artemis in speaking to him. Her body posture became more confident, her voice became stronger and louder. She reported later that she felt a physiological change in herself, a sense of herself as "lighter" and more articulate. She was able to carry this felt sense from the enactment in group to the relationship with her father outside the group.

I stress these empowerment experiences for trauma victims because the symptoms of PTSD (intrusive memories of the trauma, hyperarousal, restricted range of affect) are exacerbated or even caused by avoidance of stimuli associated with the trauma. In order for the client to develop strengths that can enable him to face the trauma and integrate shattered parts of the self, the client's role repertoire needs to be expanded to include assertive and mastery roles.

Since a survivor needs interpersonal supports as well as intra-psychic ones, and since detachment from others is a symptom of PTSD, I work with the psychodramatic concept of "the social atom" in trauma treatment. An individual "social atom" is basically a current interpersonal map of the individual, which indicates how much influence (negative, positive, or mixed positive and negative) significant others have on the client. The social atom, as an action technique, can be used with varying degrees of distance, depending upon the stage of treatment.

The most distancing use of the social atom entails having the client draw this interpersonal map, using triangles to indicate men and circles to indicate women and dotted lines to indicate someone in the social atom who is no longer living. The degree of importance an individual has to the client is indicated spatially on the sheet of paper. Like setting down on paper another family "map," the genogram, the social atom exercise of putting interpersonal dynamics in some structure and looking at them with a therapist can be clarifying. Drawing and discussing the social atom is the most distancing use

of this technique. If the client is ready, the social atom can be "sculpted," or made three-dimensional, using scarves or other objects. In a group setting, participants can take roles in each other's social atoms; in individual treatment, the therapist can take certain roles. Just seeing the roles of the social atom embodied, sculpted in a characteristic pose, can be much less distancing than seeing the social atom on paper.

To continue on the spectrum from most distanced to least distanced—using the social atom to work with the client's interpersonal relationships—I ask the client to add verbalizations to the physical posture of the particular roles in the social atom. This verbalization can be a characteristic phrase the role might use, or a message to the client. Having the client speak to the role after hearing the verbalization is even less distancing, and finally, having the client role-reverse with others in her social atom and work psychodramatically with material that comes up is the least distancing approach I have used with this technique.

Messages received from significant others in childhood often become inculcated and transformed into self-definitions. One of the ways that I put into action these interpersonal and intra-psychic messages and give the client a sense of control over them is by having the client become the "conductor" of the messages from the social atom. I can do this in group treatment by having other group members take the social atom roles and have the client give each role a phrase or sentence to say—the message to the client. Then the client treats the roles as if they were an orchestra, pointing to them when she wants a line repeated and indicating at what speed and volume. The metaphor of the "conductor" of internal messages can be invoked during later phases of treatment when the client experiences anxiety and depression and the destructive and sabotaging messages attached to these mood states. Self-sabotaging thoughts arising from the trauma are often uncovered during the exposure phase of treatment. Having the role of "conductor" can be a starting point to begin to contain and modify those thoughts.

Group treatment was often used at the Vet Center as a supportive adjunct to individual treatment of trauma. Perhaps a client was not ready to speak to other group participants about his trauma. However, a client might be willing to participate in a role-play session about the problem of sexual trauma in the military, helping to create a composite character that had been traumatized. Again, this role can serve as a "mask" that can help clients start to access and contain feelings related to their trauma. Enacting a fairytale

about injustice is more distancing than enacting a scene in which your supervisor accuses you of provoking a rape.

Most of the drama therapy techniques described thus far have been toward the over-distanced pole of the spectrum. Most of the above-mentioned techniques are for the purpose of symptom management (e.g. detachment from others, restricted range of affect) or strength-building to cope with exposure to memories of the trauma. Now I will describe more under-distanced drama therapy techniques to be used in the exposure phase of treatment.

The goal of exposure therapy with clients diagnosed with PTSD is to reduce the conditioned response of triggers associated with the trauma. In other words, avoiding stimuli related to the trauma maintains the symptoms of the trauma (G. Leskin, personal communication, 3 December 2003). Using systematic desensitization (described above) as a model, drama therapy techniques enhance the immediacy of the imagined triggers for the client's anxiety related to the trauma. To begin with, in individual treatment, I work out a desensitization "scale" with the client. The scale runs from 0 (no anxiety) to 10 (the highest level of anxiety). The client describes triggers (places, people, activities) for each number on the scale. For example, one client described herself at the 0 mark on the scale when sitting in her bedroom at home by herself. The number 10 on the scale was being at the site of the trauma. At this stage in the therapy the "zero" mark on the scale has already been made tangible by embodying strength and support figures and enacting nurturing spaces. These can be drawn upon or accessed as the therapist and client work upward on the desensitization scale. The client returns to these embodied figures and places when anxiety on the "higher rungs" of the scale becomes intolerable.

In working through the next stages of the desensitization scale, I have the client set the scene for the next trigger. I am usually asking her to describe sensory details about the scene: sights, sounds, smells, tastes. I am director in the scene as well as double. Doubling often deepens the emotional expression of a client, as well as embodying a support or holding environment for her. As double, I assume the body posture of the client and speak as an alter ego, using "I" statements. (Assuming the body posture of the client enables the double to make better "guesses" about what the client may be thinking or feeling but not saying.) As double, I can draw the client's attention to discrepancies between verbal content and nonverbal expression. For instance, "I say I'm not angry, but my fists are clenching." However, the

double is under the "control" of the client. If the doubling statement is not accurate, the client says what she is really thinking or feeling. (Doubling statements must be filtered through the client. Accentuating this control for the client is especially important for trauma survivors who have had their control ripped from them.)

Since the idea of the desensitization scale is to desensitize the client to anxiety related to trauma triggers or memories, I find it helpful to concretize the anxiety so that the client can see the anxiety as separate from the self. The client receives the message that he is *not* the anxiety. As with the client mentioned above who projected her "I'm not good" messages to herself onto the black scarf, I ask clients to choose a scarf or other object to represent the anxiety. Not only does the client have the experience of seeing the anxiety outside the self, but he can "pick up" the object representing anxiety as a nonverbal cue to the therapist that the anxiety is becoming too severe, and that it is time to drop down to the previous rung of the desensitization ladder or scale. As discussed earlier in this chapter, the goal is for the client to achieve "aesthetic distance" in regard to the trauma and to be able to remember the traumatic event without being overwhelmed by feeling or dissociated from that same feeling. As the client navigates the desensitization ladder, rung by rung, going forward, stepping back, being doubled by the therapist, mastery over the traumatic material is slowly accomplished. Once the scene of a triggering event, place, person, or object is enacted, in as much sensory detail as possible, the client is asked to soliloquize as she approaches this triggering stimulus. In this way she is developing an observing ego (with the help of the double) in regard to thoughts and feelings about the trauma stimulus, and simultaneously gathering the shattered parts of the story of the trauma into a more cohesive whole. Dissociated feelings and memories of the traumatic event become more intelligible and less frightening when they are no longer in the shadows or split off from the client's consciousness.

Case example

One of the clients I worked with had a recurring dream of a hospital door that she was afraid to enter but that she felt compelled to go through. In the dream she could not go through that door. The image of that door was number 7 on her desensitization scale. As we moved toward the "door" she was gradually able to contain the anxiety surrounding the image and she was able, in action, to open the door and see what was

behind it. What lurked behind it was her grief and fear experienced as a triage nurse in Vietnam. This trauma had been entangled with another more recent event. The exposure work helped disentangle the two traumas and allowed her to grieve the previous losses, dissociated long ago, but brought to the surface of her consciousness by the current crisis.

I often have the client take the role of an aspect of a triggering image or an object in an enacted place. Taking a more distanced role such as a bedstand or a window or a sound can conjure up information that is not so accessible by directly asking the client. Taking on the role of objects or elements puts the client directly within the triggering stimulus, but in a position to take a more cognitive or analytic approach. In terms of aesthetic distance, he is neither avoiding the stimulus nor being overpowered by it. When the "scene" has been set, he can either walk through the scene, telling whatever "story" the stimulus provides about the trauma, or "tell the story," as if watching a videotape. I ask the client to describe what is being "seen" as if it is in the present tense. I give him an imaginary "remote control" so that he can pause the action, rewind, stop, or fast forward. The understanding is that missed "parts of the video" will be "retrieved" at a later point. I continue my role as a double in both supporting the client and helping him differentiate and express feelings.

Sometimes I have clients "rewind" the tape and image a different scenario, perhaps speaking to someone associated with the trauma, or a younger version of themselves. This is a variation of talking to a younger photograph of the self, or a younger self imaged in an empty chair. What makes this approach more under-distanced than the earlier work with the photographs is that the client is speaking to herself while actively engaged in confronting stimuli associated with the trauma. Sometimes I ask clients to image one of their strength figures accompanying them as they go into the "video" and advocate for themselves. This is particularly effective if the trauma occurred in childhood. The adult client can "retrieve" her traumatized child and can then "speak" to the child, acknowledging that she is no longer the helpless child, but that the helpless child is still a part of the self.

Case example

One of my clients felt rage toward her teenage self, whom she blamed for a rape that occurred when she was beginning her military service. In the exposure phase of treatment, she was able to acknowledge the fear

> lurking behind that rage…fear that she could not, even as an adult, take good care of herself. This client was able to express this and also to acknowledge what she still retained from her teenaged self—altruism, a sense of social justice, a love of nature. However, she was able to grieve those parts of herself that had been modified in the wake of the trauma and in growing up. She was no longer a trusting 18-year-old. Her "naïve" self was balanced out by another role—a wiser, cynical adult. The "older" roles had the strength and judgment to take care of the "younger" roles.

Periodically, during treatment, I have found it helpful to continue enacting timelines, in order to consolidate the filling in of gaps in the "story" of the trauma. Memories that had been hazy or unapproachable before are now part of the fuller picture. The person has a part of his life back that was split off. Setting up a "new" timeline with formerly inaccessible material can be a useful ritual to honor the progress of treatment.

The management of PTSD symptoms is often an ongoing process, depending upon several factors, including severity and complexity of the trauma, and length of time within the traumatic situation (Calhoun and Resick 1993). However, by developing and rehearsing different strategies for coping, within a drama therapy frame, trauma survivors can access tools with which to contain these symptoms. Following is a summation of the above-mentioned drama therapy techniques used for the containment of PTSD symptoms.

Summary

- Enacting safe and nurturing places which are then anchored into the body is a useful technique for containing anxiety or increased arousal.
- Embodying nurturing, wise, and courageous figures or roles (both intra-psychic and interpersonal) that counterbalance negative messages helps contain self-blame and guilt.
- Objects or images representing the inner resources of the client can be used as talismans to hold onto during exacerbation of symptoms.
- Restriction of affect can be ameliorated by working with masks representing different feelings. These masks can then be used in role-plays which help in the identification and expression of a

range of feelings. Feelings "masked" by a preponderance of anger or depression can be revealed.

- Doubling by peers in group treatment or a therapist in individual or group treatment can aid the client in emotional expression.
- Working with the social atom of the client in a variety of ways can clarify relationship difficulties and identify sources of tension within the relationships.
- Role-plays and empty chair enactments can become behavior rehearsals for addressing significant others.
- Avoidance of stimuli associated with the trauma can be gently addressed by the enactment of timelines or by addressing photographs of the self before and after the trauma. By avoiding trauma stimuli, exposure work using drama therapy techniques can enable the client to alleviate the severity of intrusive memories and move forward.

This chapter has outlined a course of treatment for the symptomatology associated with PTSD. By beginning with over-distanced techniques and moving toward under-distanced techniques, the therapist hopes to help the client move toward aesthetic distance in remembering the trauma. "If the reason one represses emotion is that it is too painful to look at, then how can one ever be able to bring that painful moment to consciousness? The answer is that at aesthetic distance one is able to simultaneously play the role of the actor, who relives the past, and the observer, who remembers the past" (Landy 1994, p.114).

I approach treatment by shoring up strengths and supports for the client, basically trying to develop positive self-objects through enactment. Projective devices such as masks, mythology, and composite characters are over-distanced techniques used to begin to inform the client about the issues involved in trauma recovery and begin to access feeling states about those issues. Under-distanced techniques, such as speaking to pictures of oneself before and after the trauma and working through relationship tensions using the empty chair technique, are employed as a mid-point between the over-distanced projective techniques and exposure treatment using a desensitization model.

In the exposure phase of treatment, I help the client enact imagery on a scale from zero anxiety-producing stimuli (0) to the most anxiety-producing

stimuli (10). Safety checks are built into this phase of treatment, for example, having the client control the imagery via an imaginary "remote control." Supportive "places" and roles from the earlier, over-distanced phase of treatment are also available as containers for the client's possible overwhelming affect. Throughout treatment, cognitions that are sabotaging to the self are made tangible by projecting these messages onto objects, and exploring the etiology of those messages via work with the client's social atom.

The road to aesthetic distance with trauma survivors is not a linear one. As with the desensitization scale, the client will take a few steps forward and then a few steps backward. The exposure phase of treatment may have to be put on hold for a while as more work is focused upon symptom management. One of my clients reported feeling relieved that she could finally speak about the trauma without feeling debilitating self-loathing. Her recovery was not complete, but she felt that she could move forward in her life.

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Chapter 4

An Expressive Arts Therapy Model with Groups for Post-Traumatic Stress Disorder

Susan Hansen

This chapter sets forth a model of group treatment for children who have been impacted by abuse and neglect. An overview of group therapy theory precedes a brief review of my integration of recent trauma research with direct clinical practice in the field. This research has served as a foundation for the treatment model as well as a rationale for the use of expressive arts and play therapy with children who have developed post-traumatic stress disorder symptoms (PTSD). A case example will be presented to demonstrate how theory and practice can be integrated. The remainder of the chapter focuses on the specifics of this particular treatment model.

It is my belief that the purpose of clinical interventions should be to provide children with experiences and therapeutic relationships that support the development of internal coping mechanisms that sustain a healthier, more resilient functional level. Group therapy can be an effective component in a multimodal treatment approach for the provision of services with this population.

Group therapy has long been deemed a model of treatment having the capacity to significantly benefit its members. There are many approaches to group therapy and many theories to guide the therapy process. Yalom (1985, cited in Bernard and MacKenzie 1994) introduced the here-and-now approach to group therapy and postulated that the group process provides curative or therapeutic factors, including the instillation of hope, universality, imparting of information, altruism, corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis and existential factors

(Bernard and MacKenzie 1994, p.207). Von Bertalanffy developed the "living systems" theory of group therapy. "Living systems share certain properties; the group as a whole has the same qualities as other living systems. System theorists argue that it is important for group therapists to analyze the health of their group's system and to learn how to doctor it when necessary" (von Bertalanffy 1966, cited in Bernard and MacKenzie 1994, p.201). Groups with a cognitive-behavioral approach focus on changing certain aspects of the members' thinking process or behaviors. Clinicians who work from a cognitive-behavioral perspective "…make the assumption that if certain negative thinking changes or if maladaptive behaviors change, the person will also change; that is, if you change one part of the system, then the entire system will necessarily change" (von Bertalanffy 1966, cited in Bernard and MacKenzie 1994, p.209).

A literature review of group therapy models for children who have survived abuse yields few outcome studies, despite many published manuals for group therapy with this population. According to Cohen, Mannarino and Rogal (2001, p.124), "there is a relative paucity of empirical research with regard to effective treatment of PTSD in children." Despite limitations in the research field, clinicians have been faced with the challenge of providing therapy to children who have struggled with a host of traumatic experiences. These children must be afforded the support necessary to continue with their lives in ways that more resilient children are able to do without therapeutic interventions.

Groups for children who have had similarly traumatizing experiences lessen the loneliness of victimization. Many children feel singled out by trauma and interpret this as having to do with something wrong within them. Sitting with a group of peers who have all gone through a similar traumatic experience can be the most powerful support a child can have in rethinking the meaning of her experience (Monahon 1993, p.160).

Powell and Faherty (1990) have published their 20-session group therapy plan for treating sexually abused latency-age (the Freudian developmental stage between six years old and puberty) girls, in which they state (p.35), "Current research as well as the cotherapists' experience indicate that the meld of group process and the creative arts therapies with the specific development stage of latency will have positive results in the treatment of sexually abused children." Their 20-session group program involves an introductory phase with the goal of establishing safety and trust within the group process. In the next phase, known as the "commonality of experience"

phase, the group members share their own experiences and feelings related to their experiences. The next phase, the "integration phase," supports a reworking of the trauma. The final phase is the "termination phase" where many specific issues of loss are addressed and the overall termination process occurs.

Corder (2000) has published her work in creating groups for sexually abused children and adolescents and has outlined her goals for group treatment. These goals include "Improving cognitive and emotional mastery of the trauma… Building self-esteem… Improving problem-solving skills… Developing or improving communication, understanding, and coping between mother or caregiver and child victim." (p.10). Corder writes about "increasing individuals' sense of control over their bodies and environments. Strobel and Glueck (1973, cited in Corder 2000, p.380) have written that this type of training is a structured form of 'self learning to incorporate the concept of individual responsibility' that places people in a 'position of importance in their own prevention and treatment programs.' It encourages a sense of mastery over memories and feelings engendered by the abuse experience" (p.10).

The group model presented in this chapter holds to an eclectic approach deriving from a combination of the tenets espoused by the here-and-now, living systems, and cognitive-behavioral approaches. This chapter will present a group therapy model with a unique framework in a clinic setting. The model integrates the use of play therapy and expressive arts with cognitive-behavioral techniques in a process-oriented, here-and-now framework. Before discussing the specifics of the treatment model, it is important to provide a brief summary of current trauma literature as informed by my direct clinical experience. The framework for this program has evolved from an understanding of current information available in the field.

Fortunately, the majority of children exposed to abuse and traumatic stress do not develop chronic PTSD symptoms. Kulka *et al.* have reported that "…about half of the general population will experience a traumatic stress at some time in their lives. Of these, about 15 per cent will develop chronic symptoms of post-traumatic stress disorder" (cited in Bremner 2002, p.19). Van der Kolk has reported, "Only about a third of abused and neglected children in clinical settings meet diagnostic criteria for PTSD…" (Yehuda 2002, p.131).

Perception is a key component in determining whether one deems an event or series of events to be traumatic, or whether one deems them simply to be unfortunate, unique events. How the events become contexualized within the framework of the child's life makes a critical difference. If the child's world view begins to shift so that she begins to see the world as dangerous and unpredictable, PTSD symptoms are more likely to develop.

Expressive arts and play therapy techniques can be effective at supporting a process of healing. The use of expressive, nonverbal mediums can provide an avenue to address behavioral and emotional symptoms while continuing to be mindful of the physiological changes that occur when children have been exposed to traumatic events that have led to PTSD. When a child suffers from PTSD, a particular symptom profile is often present and a variety of structural shifts can occur within the brain. The physiological, structural, and organic changes have been researched extensively during the last few decades. Van der Kolk and other researchers have begun to clarify some of the mysteries behind the symptom profiles of those with PTSD. A full review of this research is beyond the scope of this chapter, yet much of the research has served to inform the structure and focus of the group model being discussed. It is my experience that when children suffer from PTSD there are cognitive distortions, behavioral and emotional regulation issues as well as a host of interpersonal limitations and a compromised sense of self. In addition, children struggle to process information accurately, as misperceptions and skewed world views begin to form. In traditional forms of talk therapy, the child is asked to speak directly about the trauma. When a child struggles with some of the limitations mentioned, she is ill equipped to engage verbally in dialogue with the therapist.

Play therapy and expressive arts can help children access, process, and integrate traumatic material in a manner that allows for appropriate resolution. Once an experience is accessed through play, there may be an opportunity for the more verbal, cognitive techniques to be effective, and after re-enacting abusive events or some aspect of them, a child or adolescent often begins to develop a more organized, less impulse-driven behavioral response to those events. Once she has begun to engage in a nonverbal activity that allows for some preliminary processing of the material that is being defended against, the magnitude of the affective response is minimized and there is a greater ability to manage impulses. For this reason I believe that a combination of expressive arts and play therapy with sequenced cognitive-behavioral, skills building therapy within the group

process can be an effective treatment strategy for this population. This belief is the foundation for the expressive arts group therapy model.

The following case example helps depict how a child who struggles with PTSD symptoms, cognitive distortions, impaired information processing, and impulse-driven behaviors can benefit from the type of treatment that the expressive arts group therapy model provides. This is not a case-specific discussion about a group process, but rather about the process that can unfold for an individual child when she engages in expressive arts and play therapy—in this case a ten-year-old arrived in my office and unexpectedly provided an incredible learning experience that has served to inform my work from that day on. The learning came not from verbal exchanges but rather from the complex, nonverbal process that provided a wealth of information, free of the distractions that so often clutter the therapeutic relationship when words and verbal interaction is the focus.

Case example: "I can talk now"

A ten-year-old girl, Maria, was referred for therapy by her caseworker due to her extensive psychiatric history, which included several psychiatric hospitalizations for suicidal ideation as well as aggression towards herself and others. She was residing in an out-of-home placement due to "out of control" behaviors that her mother was unable to manage in the home. Upon reviewing referral information, I became aware that she had alleged sexual abuse at an early age by a relative. It appeared that her behavior escalated shortly after her disclosure. Few details were available regarding the extent or duration of the abuse. She and others in her life reported little benefit from her past participation in outpatient and inpatient therapy. She had, apparently, been unable to engage or fully participate in the therapy relationship. Her verbal skills were limited and she had little motivation to engage.

During the first two sessions, I attempted to align with her through use of play materials and by making few demands for any "verbal" interaction, unless initiated by her. To my surprise, she appeared quite engaged during these two sessions. However, during Maria's third assessment session, she was mute and presented with a great deal of anxiety. She had difficulty sitting still in her chair and was unable to focus, and her breathing pattern was erratic. I chose to share with her my concerns about how she was presenting and acknowledged that because I had been seeing her for only a short period of time, I didn't know her well

> enough to suggest what we should do during the session. I said that I hoped she would be able to use the time well so that she would not need to be hospitalized. I was concerned about Maria's demeanor because former clinicians had indicated that she presented in a similar manner prior to each hospitalization. Despite her earlier refusal to engage in any verbal discussion, she did request to utilize the sandtray. Her ability to request this may have been due to the non-directive nature of the interaction between us, as well as to a sense of empowerment arising from my request for her to lead the process. She proceeded to create in the sand a scene that was filled with chaos and fear. This creation was completed within a 15-minute period, at which point she literally slumped to the ground and stated, "I can talk now." She then was able to share about a recent altercation with her foster-mother which she feared would result in her removal from the home. We were able to discuss a plan to help her avoid this. She later shared that this had been her first experience of communicating about a problem before it resulted in a truly negative consequence.

I believe that a process occurs in creative, nonverbal forms of therapy that not only allows for an opening into the child's world, but also facilitates future verbal communication. By engaging in a nonverbal, play therapy activity, Maria's defenses were minimized and she was able to manage her emotional process in a manner that served to support her more rational, logical side.

Maria was eventually referred to the expressive arts therapy group. She met the criteria for the group and was a perfect candidate due to her traumatic childhood experiences, her history of failed treatment attempts utilizing verbal therapy modalities, and her general symptom profile. I will now review the specifics of the treatment model.

The expressive arts group therapy model

Group conceptualization

The expressive arts group therapy model has relied a great deal on Finkelhor and Browne's (1985) conceptualization of the four traumagenic dynamics which are at the core of how child sexual abuse survivors are impacted by their abusive experiences. These dynamics include:

- traumatic sexualization
- betrayal

- stigmatization
- powerlessness.

Within the group process these dynamics are "played out" at various times between the group members. The group facilitators must be aware of this process in order to provide for a corrective experience and to begin shifting patterns of behavior and skewed perceptual processes.

Within this group model there is a clear group structure embedded in the larger, process-oriented framework, where the facilitators are "present" within the group process. The challenge is to support the needs of the group and to be aware of the subtle communications between group members. The group facilitators must be attuned to verbal as well as nonverbal interactions within the group and to the way these communications may be conveying a great deal of information about how the children think and feel about themselves and the others in the group. The process is of greater importance than the content of the curriculum.

No other group is more challenging then the latency-aged survivors group, possibly because latency-aged children who have struggled with abuse often lack a variety of basic skills that make functioning in a group very challenging. It is for this same reason that the group therapy experience can be one of the most effective therapeutic processes for children presenting with trauma-related symptoms. Children with trauma histories often have extremely limited social skills, difficulty modulating their affect, poor sense of self and difficulty remaining grounded in the here-and-now. These limitations pose a great challenge to group facilitators who are attempting to help the children process their experiences, learn new skills and begin the task of recovery and healing. These limitations often result in the need for concrete skills building experiences within the group.

The expressive arts group therapy program is driven by the belief that children who have experienced abuse, followed by the development of an array of PTSD symptoms, require the support of other peers to help manage the "after-effects" caused by their abusive experiences. The group provides an invaluable forum in which to manage, understand and gain insight into their various symptoms. There are three proposed levels, each one consisting of 12 weeks.

Group structure

The group members attend the group for a period of 90 minutes. During this time the structure is as follows:

- group opening
  - introductions
  - tell group your name
  - answer one question (related to group focus, e.g. "Can you name two feelings?")
  - review group expectations and rules
  - announcements—each group member is given the opportunity to share any event that has taken place in her life since the last group. This section of the group opening increasingly becomes a focus of the group, the longer the group meets. It allows the group members to connect and to receive support for simple and complex issues. Announcements include school grades, peer conflicts, fears related to family issues, court, etc.
- group activity
  - expressive arts/play therapy activity
  - photographing expressive arts activity
  - discussion of expressive arts activity
  - with facilitator (Level 1)
  - with entire group (Levels 2 and 3)
- group closing
  - rate the group 1–10 (1 = bad group, 10 = great group)
  - say what made you rate it that number
  - what was the best thing about the group?
- group snack.

Group stages

This group program is rather unique in its three-tiered system, which is meant to provide for an incremental process where the trauma treatment

evolves as the child's capacity to manage the material grows. The group addresses basic interpersonal issues as well as abuse-related symptoms ranging from poor self-image to self-injurious adaptations to problem-solving concerns. The expressive art activities provide the medium through which the facilitators can view the child's world, and also provide the vehicle for growth and change.

LEVEL 1

The 12-week introduction group is designed to introduce group members to the group therapy process and involves the use of nonverbal, expressive arts activities designed to provide a forum for the processing of internal conscious and unconscious material. The group activities are developed and based on tenets from play therapy, art therapy, and sand therapy.

The group goals and objectives were derived to address the typical symptoms experienced by children who have been traumatized, with a specific focus on Finkelhor and Browne's (1985) four traumagenic dynamics. The structure of each group provides an opening that promotes and supports verbal interchanges about present-day events and allows for group cohesion and trust building. The art activity focuses on the group goal and objective for each particular group, allowing for the members to begin to create a new outlet for self-expression. The group closing aims to integrate the group experience and to provide closure for each group meeting.

During this stage of the group process there is no verbal discussion regarding each member's individual trauma or difficult life experiences. Group members are told that they each share common experiences, but that they will not be asked to verbally share about them during this stage of the group. The members do share their individual artwork with one of the facilitators, and a photo is taken. These photos are compiled during the group process and given to the group members during the termination session. This individual sharing process becomes the foundation for future sharing with the whole group in Levels 2 and 3.

A final, but important, focus of this group is to introduce relaxation and grounding techniques to prepare each member for the more verbal sharing of information at the later stages of the group process.

LEVEL 2

Over the next twelve weeks, Level 2 continues the process of building a cohesive group and addressing issues of trust and teambuilding. In addition,

there is an increased focus on self-expression and skill enhancement in the area of feelings identification and feelings management. Group dynamics are explored and processing of more personal information through the use of metaphor is encouraged. There is movement toward a higher level of insight, without conscious interpretation of group members' expressive art creations. Group members are encouraged to share their artwork with the group (unlike Level 1) and to discuss the metaphors generated in their expressive art creations. No direct discussion regarding personal traumatic material occurs.

The structure of the Level 2 group remains the same as the Level 1 group. The focus at this level is to:

- increase verbal communication via metaphor
- increase coping skills (i.e. establishing internal safety, identifying external supports, managing triggers)
- improve grounding techniques
- use metaphor to allow for the beginning of the processing and integrating of traumatic material.

LEVEL 3

The final 12-week group in the series begins to focus on verbalizing traumatic material and introduces the conscious connection between the metaphors created in Level 2 and the personal history of each child. Members are encouraged to tell their personal stories and to integrate traumatic material in an attempt to create meaning for the personal events in their lives. The members are not pressured to share but are encouraged and supported in this process. Skills learned or enhanced in Level 1 and Level 2 continue to be supported in the attempt to use coping strategies to manage the emotional material that is being verbally discussed. Cognitive techniques are utilized to help support the expression and the management of emotion, and psychoeducational material regarding trauma is provided.

When children enter the program, they are encouraged to engage in verbalization pertaining to here-and-now events, during the group meeting. They are then introduced to the group experience and how they might learn to utilize art and the art process as a way to communicate to others. As the children progress into Level 2, they are encouraged to deepen their experience in the creation process by exploring metaphors communicated in the art

or play activities. The facilitators remain within the metaphor and explore the children's process, avoiding interventions that might encourage interpretation or removal of material from the metaphor. Common metaphoric themes begin to emerge and often provide the group facilitators with a great deal of information about the group members' internal process. The members begin to share with each other through the metaphor, and group exploration begins to occur regarding themes that emerge. Common themes include power and control issues, safety issues, desire for nurturance, fear of abandonment, aggression, and drives toward mastery. When the members enter Level 3, the facilitators initiate transition from the metaphoric themes to the reality of the members' lives. Members are asked to explore how various themes are "played out" in their present-day lives and how they have been "played out" throughout their histories. The expressive art activities begin to require less time within the group session and the discussion becomes the primary focus. The art creations then become the vehicle to contain and manage the processed material.

I have found that during Level 1 of the group program, members often struggle to engage verbally, relying on the use of the art materials to communicate. As the group progresses and the members begin to feel more comfortable with the mediums and to become aware of their shared experiences, they often find themselves at the other end of the verbal spectrum. They begin communicating all of their needs, dislikes, annoyances, interpersonal gripes, and so on. It appears that they are initially very "shut down," and then once they "open up," the flood gates are released. They begin communicating about almost every interaction that occurs. "How come you're looking at me like that?" "I don't like the way you said that to me." "He's being nice to her, but mean to me. How come?" "She's always so quiet, it makes me nervous." "Don't talk with that nasty voice, I feel scared." The management of the group becomes more about supporting the members' ability to find their own voices and establish their own communication patterns and boundaries. This process is of value, since most group members do not have the support outside of the group to begin to develop these skills.

The following case example provides some insight into the intensity of the group process and how, as the members progress through the stages, different material emerges that has a powerful effect on the group dynamics in "the room."

Case example: boundary violation

During Level 2 of the group program, the group was developing a sense of connectedness and the members had found a voice to begin expressing their feelings regarding each other. Group members were engaging in a great deal of confrontation with other members' behaviors.

During this particular group, Michael became physically aggressive toward Paula. Michael had misunderstood a comment made by Paula and reacted to what he thought was a negative comment about his mother. With what appeared to be little provocation, he quickly stood up from his chair, took a giant step toward Paula, and grabbed her. My co-facilitator and I quickly reacted. I put my hand on Michael's shoulder and firmly stated, "Michael you are not going to hit Paula, so let's make the choice to leave the group room now. Follow me." He responded as if he were relieved. I escorted Michael through the hall to my office, where we carried on a dialogue about the process that had just ensued. The other facilitator managed to process the event with the group after briefly leaving the room with Paula in order to ground and stabilize her. This process was quite challenging and frightening to the group members, as well as to the facilitators. The obvious concern with an event of this nature occurring in a trauma survivors' group is the potential for retraumatization of the group members. Despite this concern, we attempted to utilize this experience to process an inappropriate breach of safety in a manner that might result in a sense of empowerment and greater level of awareness.

An interesting process occurred as the remaining group members sat in the group circle. They initially engaged in a giddy kind of laughter, attempting to make light of what had just occurred. They attempted to minimize the event, despite their physically agitated presentations. They began to rationalize why Michael might have become aggressive, and in many ways began to identify with the aggressor. This was what many of them had done with the perpetrators of their abuse. They minimized the severity of the act of aggression and some even began to question what Paula might have done to provoke Michael. Once Paula re-entered the room, the details of the event began to escalate, as Paula actually alleged that Michael had punched her in the eye, and was holding her eye, indicating that she was in pain. Due to Paula's skewed perceptual process, she had internalized the experience as having been more physically threatening and hurtful than it actually was.

I continued to process with Michael in my office while the other facilitator processed with the group. With support and prompting, Michael was able to acknowledge how inappropriate and unsafe his act of aggression had been and to share about his frustration with Paula for antagonizing him during prior groups. He requested that he be allowed to apologize to Paula.

I returned to the group to determine the next step. Upon my return, the group had begun to process the event and Paula was sharing her perception that she had been struck in the eye. It was apparent that she was physically agitated and the rest of the group was vacillating between being physically agitated and minimizing the event.

I began to explore what had occurred from a factual standpoint and to explore their responses. Once they began to discuss their experiences, they shifted from laughter to fear. They shared how witnessing this event had reminded them of their own abuse and lack of safety. The group members shared how they felt protected and safe because of the actions taken by the adults in the room. Their perception was that we had protected Paula, unlike their own experience of having not been protected from the perpetrators of their abuse. So despite our own feelings of inadequacy as facilitators, the group members viewed the response as helpful. One member shared her fear that Michael might have killed Paula if we had not been there. This led to a discussion about vulnerability and how they might begin to explore ways to work toward preventing revictimization in the future. A sense of empowerment began to grow. This discussion led to the perception that Paula had been antagonizing Michael during the last several weeks, and although the reasons for this were unclear, this evolved into a discussion of how to avoid revictimization by identifying others who might not be safe. It was made clear that although Paula's actions had never justified Michael's aggressive behavior, she had chosen to initiate an interaction that would clearly agitate him. This was a pattern for Paula, as she often placed herself in a position where she interacted in a provocative manner with others who were likely to respond by violating her boundaries.

The group also processed how several of them had experienced flashbacks of their own abuse, and an educational process ensued regarding triggers and management of flashbacks. The group and Paula were then asked what to do about Michael. There was a consensus that the group members would not feel comfortable if Michael returned to the group that day, and I agreed that this would not be a safe plan.

> Paula, however, did wish to confront Michael about his behavior. She and I, accompanied by a security officer, returned to the office where Michael had been waiting. Paula entered the office and they were each given a discrete period of time to communicate their version of events and state whatever they wished. Michael apologized and Paula shared how the event had frightened her. They communicated their misperceptions to one another and I communicated that violence would never be tolerated in the group program. Michael was told that he would be unable to return to this group session, and Paula returned to group to communicate to them her interaction with Michael.

This example demonstrates a great deal about all the issues inherent in running a group for this population. Despite the incredible intensity of this group, much was learned by all involved and the facilitators became clearer about the need to structure the group and follow a clear protocol that supports consistency, clear co-leadership and the ability to balance the needs of the individual group members with the needs of the group as a whole. In order to provide for all of these various components, decisions have been made about all aspects of the program, from identifying the appropriate target population to who should lead the groups. Each of these areas is addressed below.

Group population

This model of group therapy was developed for a population of children aged between 9 and 12 who have suffered from chronic, ongoing abusive experiences and present with symptoms of PTSD. Lenore Terr would classify these clients as suffering from Type II trauma, "[distinguishing] the effects of a single traumatic blow, which she calls 'Type I' trauma, from the effects of prolonged, repeated trauma, which she calls 'Type II'" (Herman 1992, p.120). Judith Herman (1992, p.119) would describe these clients as suffering from "complex post-traumatic stress disorder." The majority of the group participants have severe abuse and neglect histories and have developed coping mechanisms which no longer work effectively. Symptom profiles include physical agitation, hypervigilence, dissociation, self-injurious behaviours, poor self-esteem, poor self-concept, mood lability, poor impulse control and affect modulation, skewed perceptual processes, and cognitive impairments due to physiological changes. Although this is not an all-inclusive list of symptoms, it encompasses those most commonly displayed by the children involved in the program.

Group referral process

The expressive arts group therapy participants are referred by their individual clinicians. All members must be seeing an individual clinician during their participation in the program. This requirement is mandatory for several reasons. The most important of these is that the simple fact that the children are involved in this program tends to unleash issues related to their histories and they require ongoing contact with their primary clinician to manage triggers and symptoms. In addition, the group will regularly "unlock" issues throughout the process, and individual therapy can support stabilization as well as growth. Clinicians often refer children who appear "stuck" in treatment, hoping that once they enter the program, movement will begin in the individual therapy process.

The group facilitators attempt to screen candidates for group participation through the lens of their primary clinicians. Individual therapists are first interviewed to determine whether the group is appropriate for their clients. Once the therapist and facilitators have discussed the group and the particular client, the facilitators will meet with the client prior to the beginning of the group. Due to time constraints, it is often difficult to organize full screening appointments but an effort is made to meet with the client. This meeting is important in order to introduce the purpose of the group, to answer any questions the client might have, and to begin to develop a connection to the child prior to the beginning of the group.

Group criteria

The exact criteria for the group are flexible and often shift to some degree from session to session. The specific ages of the clients are often determined by the referral pool. There is an attempt to maintain as little age difference as possible within the range of 9- to 12-year-olds. The child must have experienced an abusive event or series of events and there must be a symptom profile correlated to the abuse. The abusive experiences can include sexual or physical abuse and often include, in addition, the witnessing of violence and psychological abuse, as well as deprivation and neglect. The child must have some conscious awareness of her abuse history but does not need to have fully processed the experience. There must be an ability to remain grounded and present within the group, with some ability to manage the dissociative process. There must be a reasonable degree of certainty that the client will not be highly overaroused by group participation to the extent that self-destructive behavior and decompensation will occur.

It is a challenging task to screen a latency-aged trauma survivor for participation in this group program. This may be due to the fact that regardless of how a child might present in a one-to-one individual therapy session, it is often difficult to predict how she might present in a group that by its very nature will trigger trauma-related material. There can be a variable presentation between individual and group therapy sessions. The group process requires that the facilitators be flexible enough to provide a group structure that supports a wide variety of group members.

Group members have been of mixed gender within this latency-aged group. As the goals of this group are not to share the explicit details of the abusive experience, the concerns regarding the inclusion of both sexes have appeared less dramatic. Although this topic has created a great many debates, we have chosen to run the latency-aged groups with a mix of boys and girls. It has been my experience that many of the personal dynamics between the group members of mixed gender have compelled a re-examination of boundary issues, intimacy and self-protection issues, as well as power and control dynamics, in a manner that is beneficial to the members. The mixed gender often allows for the processing of issues that might not be raised in a single-gender group.

Group facilitators

It is important to put a great deal of thought into selecting group facilitators. Due to the nature of our clinic setting, staffing and resources are often limited. We have been unable to provide for a consistent co-facilitator relationship during the history of the program, despite overt commitment to do so. The groups have been led by a combination of staff certified social workers and psychology interns. Despite the difficulties inherent in the staffing shifts, all those involved have brought a great deal of enthusiasm and goodwill to the process. The commitment of staff to the therapeutic process is what allows the process to unfold in a beneficial manner. There is little hope for success without motivation, commitment, and professionalism from the group facilitators.

The needs of latency-aged members of a trauma survivor group vary throughout the group levels. Level 1 runs most effectively with two females as co-facilitators. The combination of a male–female team at the beginning stage of the group process appears to create an unnecessary level of anxiety, and the transference becomes an intense process too early in the treatment. A male facilitator can be added at Level 2 or Level 3, as long as the group facili-

tators are able to process the dynamics that this can create within the group. Often, the perpetrators who abused the group members have been male and the introduction of a male co-facilitator too early in the process creates intense transferential processes that it may not be possible to manage at such an early stage of the group's development. In addition, a female–male dyad may be threatening in and of itself, as most of the group members have been raised in homes where there was a lack of safety and nurturance within the parent/caregiver relationship.

Despite the concerns related to managing the transition to new facilitators, there is some value in working with the group to come to terms with the shifts in a healthy manner. In many ways, the group process can provide for a corrective experience, in that they can learn to respond to changes in life in healthy, naturally occurring ways. Losses and transitions are not sought in everyday life, although they are a natural phenomenon that we all must adjust to. The group can provide a supportive, ego-boosting environment where skills can be learned with respect to managing changes and struggles.

Table 4.1 Example of 12-week curriculum

Week	*Group goals*	*Activity*
1	Establishing connection	Image of self
2	Establishing connection; self-acceptance; understanding individual differences	Same vs. different
3	Establishing connection; self-acceptance and expression	Create a world
4	Identification of feelings (general)	Puppet creation
5	Feelings (empathy)	Puppet play
6	Teambuilding (empathy toward others in the group)	Unstructured drawing
7	Teambuilding	Living world
8	Trust; intimacy with group	Magic wand
9	Intimacy; individual identity	Masks—Part I
10	Intimacy; individual identity; self-disclosure	Masks—Part II
11	Preliminary termination; integration	Hope chest
12	Termination	Good-bye

Group curriculum

Each level of the program follows a similar progression of group goals and objectives from Week 1 through Week 12, with different activities and varying levels of verbal processing. The structure of all the group levels is the same, and the goals of the twelve sessions follow a similar pattern. The main difference between the three levels is the degree to which verbal processing is encouraged and the structure and confrontation surrounding the verbalization of life experiences. Table 4.1 presents an example of a group curriculum outline for a Level 1 group.

Summary

This chapter has provided an overview of the expressive arts group therapy model from its conceptualization to its implementation. Treatment providers are always searching for new and innovative interventions to help serve various populations more effectively. This model was created to support a treatment protocol for latency-aged survivors of abuse and neglect. It was determined that by utilizing information gathered through recent trauma research with practical, hands-on experience, a model could be created to broaden the depth of the treatment process for children with abuse histories. The group structure and curriculum presented in this chapter are meant to provide the reader with a framework that is supported by fundamental tenets of play therapy and expressive arts. The model provides clinicians with another tool that can be used to support healthier, more functional development in children who have experienced abuse and neglect.

Acknowledgements

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Chapter 5

Peter: A Study of Cumulative Trauma
From "Robot" to "Regular Guy"

Eleanor C. Irwin

Historical treatment of psychological trauma

The study of trauma had its beginnings in Paris late in the nineteenth century with the work of Jean-Martin Charcot. Among those who observed Charcot's fascinating demonstrations with hysterics was Sigmund Freud, a 29-year-old neurologist. Charcot's theory was that his patients' symptoms of amnesia, paralysis, convulsions, and sensory-motor impairments were not the results of degeneracy, as had been thought, but the result of psychological trauma. These ideas intrigued Freud.

Fascinated, Freud returned to Vienna and continued to work with hysterics but, unlike Charcot, he shifted his attention to the emotional lives of his patients and to the hidden factors that predisposed women to such an illness. Using free association rather than hypnosis, Freud and his collaborator, Joseph Breuer, pursued a method of treatment that ultimately became known as "the talking cure," or psychoanalysis. In time, Freud and Breuer clearly demonstrated that the aberrant and puzzling symptoms of hysteria were the results of failed attempts to repress painful memories of past events, often of a sexual nature. Patients, they wrote, "suffer mainly from reminiscences," i.e. from repressed memories that become traumatic years after abusive events have taken place (Breuer and Freud 1893–1895, p.7).

Freud's legacy: psychoanalytic concepts in treatment

Although psychoanalysis has changed a great deal in the intervening century, some of Freud's ground-breaking theories continue to be the basis of modern psychotherapy. Some of his most relevant concepts include the following.

- Much (if not most) of everyday functioning is the result of the unconscious mental life, manifest in dreams, slips of the tongue, and neurotic symptoms.
- Emotional conflicts frequently result in symptom formation, often as the result of unconscious guilt or shame.
- Early life difficulties serve to stimulate the formation of maladaptive coping skills and psychological defenses, formed to protect the self from emotional pain.
- Therapists look for psychologically safe ways to help patients recall and work through dissociated or repressed past events that are paradoxically both "unrememberable" and unforgettable.
- Both patients and therapists "transfer" feelings from significant others onto each other; transference manifestations need to be recognized and taken into consideration by the therapist.

Psychoanalytic therapy with children

As for children, Freud theorized that painful past events could be overcome through spontaneous play, by changing passive experiences to active ones, leading to mastery through repetition (Freud 1955). Similarly, Wälder commented that play enabled the child to assimilate piecemeal those experiences that were too intense to be assimilated in one fell swoop, thereby digesting "the undigested meal" (Wälder 1933, pp.208–224).

Freud encouraged child analysis and was pleased that the results of the first child analytic case, that of Little Hans, confirmed his views about the importance of early life experiences. Following the analysis of Hans, some early analysts began to work with children, making contributions that laid the foundation for child analysis.

Many years ago, as a novice therapist, I was intrigued to read the work of these pioneers who helped children to symbolize and label feelings and ideas, as they strived to gain control in their lives. Child analysts, including Hermine Hug-Helmuth (1921), Anna Freud (1922–1970), Melanie Klein (1932), Madeline Rambert (1946), and André Lussier (1960), to mention just a few, included play activities, such as drawing, toys, music, puppets, and spontaneous dramatic play in their treatment of child patients.

In time, other analysts contributed different points of view, widening the scope of child treatment by including other disciplines. Erik Erikson

(1997), whose world view incorporated social, political, religious, economic, and scientific understandings, called play "the child's work." Erikson (1972, p.131) gave many explanations for these "condensed bits of life," including the working through of a traumatic experience; the attempt to communicate or even confess; the exercise of growing faculties; and the mastering of complex life situations. All contribute to the value of play, he said, making it "one of the most self-healing measures childhood affords."

In the generation after Freud, Donald W. Winnicott, like Erikson, linked psychoanalysis to many disciplines. As a theoretician, a pediatrician, and an analyst, Winnicott saw play as important for healthy development, as well as a means of therapy and a way of understanding pathology. Underlining the importance of the play process, Winnicott (l971, p.54) believed that only in play could the individual be creative and discover the "real" self. Stressing the importance of the therapist–child relationship, Winnicott believed that children who cannot play are unable to resolve conflicts creatively. When such a therapeutic relationship is absent, Winnicott said, the therapist's first step is to help the child to enter the therapeutic "play space," in order to engage in "as if," pretend behavior. If the child is able to enter the "play space," then she can use the therapist's help in finding ways to express and manage conflict.

Throughout his career, Winnicott focused on the importance of object relations and the early pre-oedipal relationship with the mother, veering away from the Freudian emphasis on drives and the oedipal conflict. Some of Winnicott's central concepts, applicable to work with children or adults, were the importance of the "good enough" mother, the transitional object, the "holding environment," and the therapeutic play space (1953, 1971).

Presciently, Winnicott's focus on the importance of the early mother–child bond has been verified by contemporary research. Building on the work of Bowlby (1969, 1973), current researchers on attachment (e.g. Cassidy and Shaver 1999; Main 1995), infant research (e.g. Beebe and Lachman 2002) and interpersonal neurobiology (e.g. Schore 1994, 2003; Siegel 1999; Solomon and Siegel 2003; and Sroufe 1995) have offered confirmation that inadequate attachment experiences negatively impact brain development, affect regulation, self-reflection, and social skills.

Play and expressive arts in treatment

Early in my career, working with seriously disturbed children, I read Joyce McDougall and Serge Lebovici's evocative book, *Dialogue with Sammy*

(1969). Because the youngsters I saw in therapy were very much like McDougall's patient, Sammy, I was encouraged to follow her example and that of others who used art, music, sandplay, and drama in their work. I used these modalities in a variety of settings (inpatient and outpatient treatment, community agencies, schools), with diverse populations (children, adolescents, adults, and the elderly) to supplement the more traditional verbal psychotherapy. Fortunately, I had a creative child analyst, Marvin Shapiro, who supervised my work and encouraged me to enter child and adult psychoanalytic training. I was doubly blessed in being able to work collaboratively with Judith Rubin (1978, 1984, 1987), a valued colleague, from whom I have learned a great deal.

From the beginning I quickly realized that the arts could be a powerful ally in reaching the "normal neurotic" as well as "unreachable" children (Irwin 1983, 2000). One of the main reasons the arts are so effective is because they can provide enormous pleasure. Experimenting with different arts materials and modalities is something natural to individuals of all ages, often bringing with it a sense of satisfaction. The therapist who can facilitate play is immediately rewarded with a strong connection to the other, one that colors the activity with a sense of trust and a positive attachment. This is a crucial factor in therapy, especially if one is working with a hard-to-reach patient.

Additionally, focusing on the healthy, unique aspects of the self often stimulates curiosity, a desire to create, the wish to express "hidden" wishes, and the relief of tension. The pleasure that comes from the creative process often leads to positive feelings toward the therapist, forging a treatment alliance, shared intimacy, and identification with a "new object."

In addition to these treatment components, valuable diagnostic data are communicated through the arts (Irwin and Rubin 1976). Using the expressive arts within the safety of a secure "holding environment" (Winnicott 1953), individuals can reveal a rich picture of the inner life; i.e. preoccupations, defenses and coping styles, resistances and transference–countertransference issues (Irwin 1983). In a way, the arts serve as a kind of transitional object, bringing about the "me/not me" position of which Winnicott spoke (1953). The "product" can bridge the patient's inner and outer worlds, fostering a positive connection with the therapist in a joint creative process. Multiple experiences of this kind, over time, can aid in the formation of a positive transference, one that can be immensely helpful when the going gets rough and resistances make their inevitable appearance.

The growing use of the expressive arts in treatment

In the last decade there has been a rapid increase in the use of innovative treatment approaches like the expressive arts in community agencies, schools, and inpatient and outpatient settings. Art, dance and movement, music, poetry, and drama have enlarged treatment options for the emotionally disturbed and at-risk populations who simply do not have the verbal or cognitive skills for the usual "talk" therapies.

The use of these modalities is especially helpful in work with troubled children, particularly those who are developmentally delayed or have a history of neglect, abuse, and/or delinquency. While some "neurotic" children can be reflective and use a verbal mode of treatment to gain insight that can lead to change, many children with complex disorders cannot (Fonagy and Target 2000, pp.99–143; Tyson 2005). This is especially true of youngsters who have borderline disorders, have been abused, neglected, or abandoned; or who have severe separation anxiety, mood disorders, attention deficit disorder (ADD), or attention deficit hyperactivity disorder (ADHD). For them, words may seem no more than thin air. Mistrustful, with meager verbal, play, or cognitive skills, limited in the ability to think abstractly or symbolically, these at-risk youngsters with their poor tolerance of frustration, developmental lags, and primitive defense mechanisms need intensive treatment and a play "partner" to teach skills, and to stimulate positive interaction, self-regulation and reflection.

Arts therapists, trained to use different materials and modalities, can provide growth-enhancing processes for this population through empathic listening, attunement, mirroring, understanding, and helping; i.e. the kind of environment that was most likely missing in their early years. The multiple forms of nonverbal communication available through the arts encourage communication, often at an unconscious or "non-conscious" level with this population. While words often seem to be the medium of exchange, more often therapy is enacted, rife with embodied meanings, dependent on nonverbal and presymbolic (sensory-motor) forms of communication. These primitive ways of relating represent a less threatening way of "talking" with the traumatized child. Since emotional material from the painful past is stored in the right brain as "implicit knowledge" (rather than in the cognitive/left brain as "explicit knowledge"), it is often difficult to access these images and feelings in talk therapy (Schore 2003, pp.107–167). These early traumatic "non-conscious" (i.e. right-brain) images and emotions can, however, be accessed in psychologically safe ways through expressive arts

processes that emphasize *action* and *affect*, methods that are at the core of all arts experiences. By beginning where the child is, emotionally and developmentally, therapists build slowly toward the construction of a shared symbolic world, promoting communication, integration, and healing.

Play, the arts, and attachment patterns

Some individuals develop symptoms of serious mental illness after a trauma (e.g. become addicted or suicidal), while others respond to the same event by mobilizing adequate coping and adaptive tendencies. Trying to puzzle out why some survive and others do not, researchers have pointed to strength of character, coping skills, defenses, etc. However, a surprising explanation for resiliency in response to trauma is the adequacy of the mother–child bond in the early years, i.e. attachment patterns.

The presence or absence of a secure attachment to a good-enough mother (and later, father) is not only necessary for play, but is a crucial variable in predicting later functioning (Siegel 1999; Schore 2003). An optimal beginning with a nurturing, attuned mother helps to immunize the child from later difficulties by promoting crucial brain development and a sturdy sense of self.

Insecure or disorganized attachment difficulties, on the other hand, have a negative influence on the developing brain, interfering with the infant or toddler's emotional and social development and capacities for self-regulation, cognition, and behavior. In a secure attachment, the good-enough caregiver serves as a "protective shield," whereas those with poor attachment patterns face continual misattunement with their caregivers (Freud 1955; Kahn 1963, pp.286–306). In time, these multiple breaches in the protective shield result in cumulative trauma that can be more harmful than "shock" or one-time traumatic events, as the following case study illustrates.

Peter: neglect and cumulative trauma

Early history: abuse, neglect, and reactive attachment

Salman Akhtar, Professor of Psychiatry at Jefferson Medical College, has suggested that three factors coexist in psychological trauma. Briefly, Akhtar said that in a traumatic situation three things happen: (1) good things are taken away, (2) bad things are done, and (3) everyone behaves as though things are normal (Akhtar 2005).

These three factors affected nine-year-old Peter, adopted at 14 months from a Russian orphanage, where he (and others) had suffered severe neglect. However "ordinary" these experiences may have been for him and others, long periods of inattention from caregivers constituted a breakdown in the protective shield, creating a strain that accumulated silently and invisibly (Kahn 1963). As Akhtar says, bad things happened, good things were taken away, and everyone experienced this as normal.

Understanding the impact of these multiple losses on Peter, however, meant taking into account his cumulative traumas during his early years. These included early emotional deprivation, adoption, reactive attachment, and anxious attachment disorders, unexplained separations, his parents' acrimonious divorce, his father's remarriage, many caregivers and separations, and the debilitating illness and multiple hospitalizations of his mother. Over time, therefore, early neglect, augmented by later traumas, had an increasingly negative impact on the sense of self.

This chapter will now illustrate:

1. how development can be negatively impacted by neglect and unresolved trauma
2. how these powerful interacting influences can determine a child's view of himself and his mode of relating, thinking, and behaving
3. how an expressive arts approach can foster an empathic connection, facilitating communication of non-conscious memories and fantasies
4. how these processes can lead to insight and change, forging communication and connections between the right and the left brain, altering neuronal connections, and promoting healing.

Relational trauma: referral and assessment

Peter's parents, still coldly interacting after a difficult divorce when Peter was six, referred their shy nine-year-old son, saying that he resisted new activities and seemed anxious and distrustful. Over the years, Peter had been variously diagnosed as having a reactive attachment disorder, autism, Asperger's syndrome, pervasive developmental disorder, ADD, and a severe anxiety disorder. Knowing that I had worked with selectively mute and many foreign-born adopted children, the parents wondered if I could see their child, who "*can* talk, but doesn't like to!"

In the assessment I learned that although Peter had ADD and visual-perceptual and motor problems, he enjoyed art and at times could be a skilled

storyteller. I said that it was possible that an expressive arts approach, one less dependent on words and more dependent on other forms of communication, might be helpful in reaching this mostly silent child.

Early history of neglect

Peter's background of neglect, losses, and cumulative trauma had left its negative imprint. His parents, high functioning business professionals, adopted Peter from a Russian orphanage when he was 14 months old, hoping that he would be a companion for his three-year-old adopted sister. Expecting to be given an infant, the parents made several trips to "claim" him, only to be told that the papers were incomplete. On the third trip, at virtually the last minute, the parents received a hastily bundled-up toddler and a sketchy medical report. The next day "Igor," now called Peter, joined them for the long trip home, showing little interest in his adoptive parents, new clothes, or carefully selected teddy bear.

During the assessment process Peter's father reflected on this chaotic beginning, saying that it seemed strange that Peter showed no overt reaction, no tears or anxiety in leaving, no pleasure in being cuddled. This information troubled me, and left me wondering about the quality of his attachment to his early caregivers (Mahler, Pine, and Bergman 1975; Main 1995).

Peter's parents gave me a video showing the children in the orphanage at mealtimes, bedtime, and playtime. The parents commented that most of the children shown on the tape were unspontaneous and robot-like—including Peter. Asked how their son managed the "culture shock" in going from one home to another, the parents were puzzled. They had not thought about Peter's suddenly being called by a different name, or being talked to in a strange language. Nor had they considered Peter's visceral/emotional reactions to being taken from an environment filled with familiar foods, clothing, toys, smells, and sounds, and thrust into a very different environment. The parents *did* realize, however, that Peter was severely neglected, being one of about 20 infants entrusted to one caregiver. Although his physical needs were met, his emotional and relational needs clearly were not.

The early years and unintended continuation of neglect

Peter's working mother was at home with him for several months, and then the toddler was turned over to his highly recommended nanny. Peter walked unsteadily at two, rarely ran for fear of falling, and at four was referred for

delayed language development. In day care, Peter was a loner, seemingly uninterested in play or social interaction. Because the parents worked long hours, they did not question his development. All seemed tranquil. When they returned home at night, the house was clean, the child was fed and ready for bed. Retrospectively, however, Peter's father realized that the "sterile" atmosphere in the home replicated, in some ways, the sterile environment of the orphanage.

When Peter was three, his pediatrician raised questions about the home environment. Surprised, the parents said that they never questioned Peter's quietness, nor the nanny's pride in the "good child" who sat quietly in the playpen. Peter's docility, the parents realized, was robot-like, eerily similar to the behavior in the videotape. Missing in Peter's home, as it had been in the orphanage, was mutual play, spontaneity, and language stimulation, the kind of "floor play" that Greenspan (1997) advocates as necessary for optimal ego development. While Peter may have been predisposed by his genetic constitution to be robot-like, so to speak, it seems more likely that his behavior was shaped by severe early neglect, which in many ways is more harmful than physical abuse (Schore 2003).

Further losses: divorce and illness

Prodded by their pediatrician, the parents found a more interactive, playful nanny, but when Peter was five, tension between the parents culminated in the father's abrupt departure from home. In anger, he took the two children on a month's "vacation" to Florida, and it was some time before the children saw their mother again. However, the subsequent separation and divorce meant yet another nanny, with the children shuffling back and forth between two quarreling parents. All of this helped to explain why Peter mistrusted others, feared rejection, and was unwilling to risk involvement in relationships.

When Peter was seven, his mother suffered a recurrence of a previous illness. Separations and hospitalizations followed, as she sought help from specialists across the country. During this chaotic time, Peter, a "good boy," lived with his father, with only occasional visits to his desperately ill mother. In time she became marginally better, but had to give up her much-loved job and employ a full-time housekeeper/nanny—yet another change for Peter.

The latency years

Peter's social and academic problems increased with age. A loner, he had few friends, ate lunch alone, and, despite good intelligence, received below-average grades. Mother was physically and emotionally unavailable, and Peter's well-meaning father was perpetually confused about whether to use the carrot or the stick with him. When his father remarried, Peter was decidedly cool to his stepmother, Roberta, a former teacher. Appalled at the child's social isolation and frustrated by his rejecting attitude, Roberta insisted on a series of evaluations and then treatment for Peter.

Initial assessment and treatment

Course of treatment

Over the course of three years of treatment, there were a number of developmental shifts that indicated marked progress, as became clear only in retrospect.

In the first three months of therapy Peter, frozen, made repetitive, primitive drawings, characteristic of a much younger child. Three months later, although still nonverbal, Peter began to use tempera paints, slowly adding color to his work.

Nine months after beginning, Peter hesitantly began to talk about books, making drawings to illustrate meaningful parts of the story.

At the end of the first year, challenged to tell his own story, Peter related chaotic fantasies, full of images of castration and death. His drawings and stories were confused and confusing, often indecipherable.

After 18 months of therapy, Peter's creations slowly began to change, with less chaos and confusion and more coherent themes. Now invested in therapy, Peter illustrated his stories and spontaneous puppet dramas with skillful drawings. Intensely ambivalent, however, he also showed evidence of a negative transference and expressed confusion about his core sexual identity.

After two years in therapy, Peter began to talk about his frightening night-time fears. Negative transference reactions intensified, but the pleasure of play seemed to keep him in treatment. Becoming more introspective, Peter talked of liking girls, but also spoke of fears of rejection, and a fearful wish to be noticed.

FIRST SESSION

Wordlessly compliant as he came for his first session, Peter was nonverbal, and his face was blank, devoid of emotion. Entering the room, he sat in the closest chair, avoided eye contact, and was completely motionless. Especially disturbing was Peter's lack of affect, as though there was complete emotional blocking. His blank face was startling, evoking a memory of my own discomfort while observing a video of E. Z. Tronick's *Still Face Experiment*, where a mother is asked to be non-reactive and show her (increasingly anxious) infant a "still face" (Tronick 1998).

During the assessment, I pointed out a range of unstructured materials, such as art materials, sandbox items, puppets, and miniature life toys (Irwin 1983). Using such materials usually helps kids to feel more comfortable, I said, and might be a way to get to know each other. Peter, frozen, took no notice and said nothing. After what seemed to be a long time, he moved his hand slowly and took a 9 x 12 piece of white drawing paper and a gray marker. Listlessly, he drew ritualized circles and squares, most with incomplete closures (Figure 5.1).

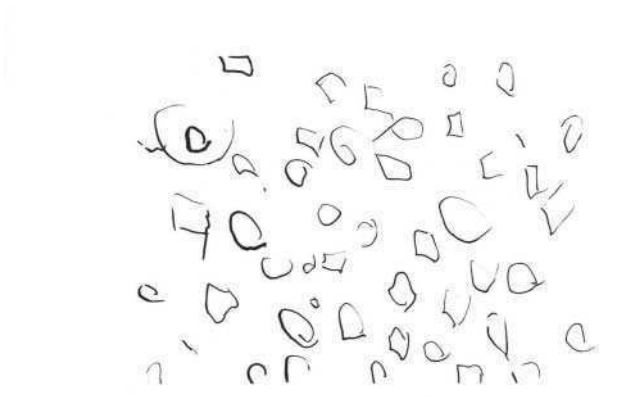

Figure 5.1 Peter's drawing from session 1

Communication, although nonverbal, was decidedly painful. Uncomfortable and anxious about the tension that was beginning to reverberate in me, I said that I could see that this was hard for him. After a bit I added that it might be especially hard because coming to see me was his family's idea, not his. I asked if he remembered some of the reasons why his parents wanted

him to come. When he remained silent, I mentioned some of his parents' worries, realizing all the while, however, that most of my comments were an effort on my part to make a connection with the "still face," as though to bring him to life.

I was struck by Peter's isolation and frozen posture, with only his hand moving slowly in an uncoordinated way. When the end of our (seemingly interminable) time arrived, I said that maybe he would come for two more sessions to see if therapy could be of help. I said, further, that I admired his courage in coming, but I hoped the next time would be a bit easier for him. As he left, he threw his picture in the wastebasket, but I retrieved it, suggesting that we keep it and look at it again. Sometimes, I said, drawings give us hints of what is going on inside of us, a kind of X-ray of our feelings. The rigidity and self-imposed silence did not change.

When Peter left, I felt exhausted, depleted. I assumed that this was my countertransference reaction, as though I had responded to his unverbalized but implicitly enacted anxiety. Although the cognitive part of Peter was not "on line," I sensed his terror, his attempt to control his anxiety through distancing techniques, perhaps even dissociating. I wondered if the early relationship pattern of rigid stillness and avoidance was being enacted with me. I also began to wonder whether it was possible for me to communicate with his closed off internal world, helping him to enter the "potential play space." These painful countertransference reactions helped me to gain a sense of his profound isolation and fear of engagement.

THERAPY, A SLOW PROCESS

I was frankly surprised that Peter elected to continue, and I continued to be concerned about my ability to reach him. His next five sessions were remarkably similar to the first, showing only the smallest change over time. Silent, he continued to make similar gray/black drawings; but beginning in the second month, he began to add color. In the eighth session Peter used tempera paints for the first time, making a series of pictures with black, vertical strokes. Two months later, his mostly black paintings changed, becoming quite colorful with strokes of blue, red, and yellow paint. His frozen stance began to thaw, with less body tension, and an occasional word, phrase, or a fleeting glance now and then. I had an image of a patient who was coming out of a coma.

During this time, still searching for ways to reach him, I asked Peter what books he had read. Hesitantly, he mentioned Harry Potter. Questioned

further, he gave me a few "facts" about the plot and characters, then volunteered that he liked Harry best. (Oh?) "Cos he's one of the good guys, not a bad guy," the longest sentence he had uttered to date. But that was it; end of discussion.

However, from that time on, Peter began to make more elaborate drawings, showing more affect. Having been told about the Harry Potter books, I was startled to discover that he could remember all the characters and the complicated plot. Next Peter told several fairytales about giants and ogres, and then he began to talk about the *Star Wars* trilogy. Although he liked Luke Skywalker, Peter seemed more interested in R2D2, the human-like robot with feelings, who is attached to others and can translate the speech of other robots (Figure 5.2). Robot-like himself, Peter's fascination with R2D2 made sense.

Figure 5.2 Peter's drawing of R2D2

Becoming invested in his artwork, Peter drew spaceships and light-saber beams, identifying each weapon with a character in the story. Warming up, he said emphatically that Darth Vader *should* be killed because he was a "bad guy" who wanted to kill his son—a theme that began to resonate (unelaborated) with increasing frequency.

During the eighth months of treatment, Peter talked about *A Series of Unfortunate Events*. The theme of these stories, like that of Harry Potter, is one that fascinates children, perhaps because it touches on the common childhood fantasy of being adopted and/or finding idealized parents (Freud

1959). In this story, the parentless children are mistreated and face constant danger, using their wits to escape just in the nick of time from Count Olaf, the villain. Drawing a picture of the fire that killed the parents, Peter, at the last minute, put my initials (E. I.) in the middle of the brightly colored fire. This highly visible transference sign was laughed off by Peter as "an accident," an unintended joke.

I asked about his fascination with this series and Peter dismissed the question with a shrug. Seeing many parallels, I said that the books reminded me of him and his life in some ways. Although I did not know of a Count Olaf in his life, Peter, like the kids in the story, had also suffered a series of very unfortunate events. He was taken away from his biological mother and father, was adopted by people he did not know, went from one nanny to another and from one home to another, experienced his parents' separation and divorce, got sick with worry about his ill mother, and then learned that his dad had remarried. Now *that* was a lot of changes and unfortunate events! Looking at me directly, Peter said, "She was going to die and I felt like killing him!", a direct statement of powerful feelings, followed by an iron curtain of silence.

PETER'S CHAOTIC FANTASY LIFE

In the next session, I wondered if Peter might be afraid of *his* strong feelings and perhaps that was why, in part, he always told "ready-made" stories instead of "homemade" ones. A few sessions later, Peter took up the challenge of relating his own stories. Chaos followed. Peter's fantasies were more like nightmares, having the quality of borderline or psychotic features. Devoid of narrative structure, they were an admixture of events without logic or rationale, with no beginning, middle, or end.

Unmistakable in Peter's fantasies was an emerging negative transference. I became the target of his aggression, mocked and denigrated. He called me a variety of names: "spook," "shrink," "Ir-whing," "Burt," "Dr. Do-Do," etc. For example, one of his stories, as best I could follow it, was this: "A little bird. Breaks his legs several times. His ankles are wrong, upside-down. There's a big light. They kill. The eagle will like this. His wife marries a flamingo ghost. They are both strong. And *you* are killed, Ir-whing! *You*, Dr. Do-Do!"

After a time, realizing that these were fantasies full of embodied meanings that were likely the consequences of his early neglect, I stopped listening cognitively. Instead, I responded to his transferences (and my countertransference reactions), to his visual images, affects, and themes.

When possible, I retranslated his allegory-like ramblings, speaking to his wish and his fear, to what was said and not said. As he worked at his drawings and puppet dramas, I commented on repetitive frightening images and affects that were alluded to but not directly verbalized "Ghosts? Again. That's scary! Especially because he's all alone." Or—"People getting killed—and me too! Oh, oh…I wonder if anyone can help me?" When I stopped expecting logic and order and focused on the discordant visual images and feelings, I heard repetitive themes of ghosts, darkness, and especially death and castration.

Peter's affect began to change. Robot-like rigidity gave way to seemingly hypomanic behavior. His eerie laugh and shrill, gleeful expression seemed to be a cover for his anxiety, as though he was attempting to protect himself from emerging frightening, unconscious images. I wondered if the chaos in his stories and drawings reflected unconscious content that he was trying to simultaneously express and control, through distancing, denial, splitting, and projection.

For many weeks, Peter made up stories about Dr. Jekyll and Mr. Hyde, focusing especially on Mr. Hyde's cruelty. His drawings illustrated a fairly placid-looking Dr. Jekyll (Figure 5.3) and a raging Mr. Hyde, contemplating murder (Figure 5.4). We talked about Dr. Jekyll's mask, and how people hide their feelings behind mask-like faces. As Peter drew, we talked of "splitting" and ambivalence (e.g. good–bad; love–hate) in his stories, ideas that reverberated in his expressions of mixed feelings about me, which were evident in the transference.

I assumed that all the "characters" in Peter's story were parts of himself (i.e. self- and object representations), and that my therapeutic task was to try to help him to look at and be more reflective about his stories and their many meanings. We began to make progress when Peter startled himself with his drawing of Dr. Jekyll's mask. It reminded him, he said, of his shyness at school, as though he was hiding behind a mask; and, he hinted, maybe the mask hid other things too. These images gave us a chance to talk about reality and fantasy, overt and covert feelings. We talked about ambivalence and how people can have loving and hating feelings at the same time; how aggressor and victim can be two parts of the same person, like Jekyll and Hyde, for example. I mentioned that people often worry that if they *think* something, it will come true (i.e. magical thinking). I also said that a person can feel stronger and more in control by learning to talk about and to tolerate "nervous feelings" (i.e. anxiety).

Figure 5.3 Peter's drawing of Dr. Jekyll

Figure 5.4 Peter's drawing of Mr. Hyde

Peter began to show increasing ambivalence toward me, with feelings amplified through his stories and drawings. He made a picture of me, for example, labeling it "Dr. Do-Do", saying that my poop would kill me. Another drawing followed, announcing: "House of Villains. No good-guys allowed, no talk-doctors" (Figure 5.5).

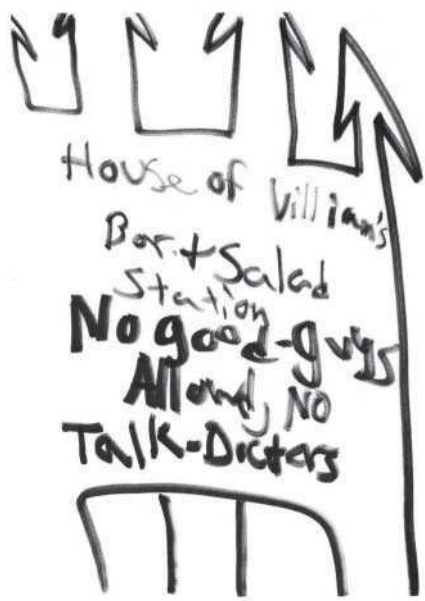

Figure 5.5 Peter's drawing of the "House of Villains"

But later in that session, as though fearing the effects of his dangerous inner urges, he quickly made several brightly colored posters announcing my (imaginary) birthday and welcoming everyone to my party.

Over time, Peter's images and fantasies slowly became more coherent, as though he was integrating split-off, fragmented parts of himself into a more cohesive whole. At the same time, he also drew male figures that he changed into females, and vice versa. Once, talking about adoption, Peter, scowling, said he wished he had never been adopted. Asked to say more, he hesitantly said he wondered if he could have been born as a girl, but turned into a boy. Or maybe the orphanage people got mixed up and called him a boy when he was really a girl. He said that maybe it would be easier for him if he *had* been a girl. Living with his mom would sure be better because "She doesn't know how to treat boys, but she's nice to my sister, alright!" If he were a girl, his mom wouldn't have let his dad take him away on vacation, and he could have gone to the hospital with her. As it was, he worried "for years," not knowing if she was alive or not.

These ideas were elaborated in a halting fashion, in bits and pieces over time, often in the same fragmented, approach-avoidance way as his first fantasies. Gradually it became clear that he was blaming someone for being "bad," the cause of a lot of trouble. This came to the fore in one session when he accidentally bumped me and became very anxious, referring to himself as clumsy and bad. When I said that was a word he used a lot, he remembered that his mom said he was "bad" and would be the "ruin" of her. Well, he wondered, could that have made her sick? This back-and-forth discussion about good–bad splits ultimately led to the topic of adoption and why kids are given away. Wistfully, Peter said sometimes he wondered about his (biological) mom and if she was rich or poor. When he grew up, he insisted, he would give all his money to the poor.

I wondered if he might be thinking that if he *was* like his mom, he would not miss her so much. Peter bypassed that comment but said that, as a girl, he could wear his mom's clothes, and could sleep with her as Betsy (his sister) sometimes does…"and sort of, *be* her, like…like Betsy." Talking about this (negative oedipal) wish, Peter added that if he were a girl, it might be good with dad, too. Then maybe his stepmother would go away, and it would be just himself, his dad, and his sister, like before. In these ways, Peter gave voice to his ambivalent feelings toward his parents, his longings and loneliness, his anger and anguish about multiple separations, and his worry that his sister was the favorite one.

NIGHT-TIME FEARS

Peter wanted to be special with both parents, not just Mom. When his father remarried, Peter, unable to sleep at night, had many terrifying nightmares that a robber would come in the window and "shoot someone." Although too terrified to talk about this anxiety, Peter was able to draw his worry. Making a series of images, he said that he was "afraid" that his stepmother, Roberta, would be killed. He drew a man with a gun who entered through a window, was shot, and taken to jail (Figure 5.6).

We had already talked about ambivalence and how fears and wishes were different parts of the same coin, and Peter could see that there might be a part of him that might wish that Roberta *would* be killed, i.e. *gone*! Then it would be like the old days, with just himself, Dad, and Betsy. Reluctantly, Peter admitted that he did "sort of" wish that Roberta would go away, but not die, really. Some few weeks later, Peter casually announced that he was again sleeping in his own room; the robber worries were gone. Peter's

newfound ability to use words and tolerate anxiety indicated a greater capacity for reflection, a developmental achievement.

Peter showed evidence of developmental strides in other areas as well. Although he continued to have problems with groups, Peter was able to make friends with two "guys" who also liked hard rock music. Invited to a party, he became exceedingly anxious, agonizing about what he would do if someone asked him to dance. Hidden behind this worry was a wish/fear that "Ellen" would want to dance with him. When he talked about this worry, Roberta said she would teach him to dance—an offer he reluctantly accepted.

Figure 5.6 Peter's drawing of his scary nightmares

TERMINATION

Peter ended treatment almost three years after beginning. While some signs of severe neglect were still present (e.g. shyness, self-conscious shame about his body), his dad described him as more like a "regular kid." His worries about being looked at began to lessen after he started to play "Russian" rock music with two friends, fantasizing about having a gig someday. When I said that this would help him learn the music of his heritage, he thought it "might not be too bad" to be on stage if "his guys" were there, helping out if "things went haywire."

Summary

This chapter has explored the case of a youngster who suffered extreme neglect, which impaired emerging brain development, cognitive, social, and emotional regulation. Adopted at l4 months, Peter was denied the opportunity of forming a secure attachment to a good-enough mother, and lacked stimulation, security, warmth, and attunement. This early, severe deprivation left Peter damaged in many ways, lonely and frightened, difficult to reach in therapy. Peter responded to the invitation to use safe, nonverbal modes of communication through his artwork, eventually adding words and action to communicate chaotic memories of his painful past. Feeling accepted and understood, he entered the play sphere and engaged in "as if" behavior, giving voice to his inchoate images and feelings (Fosha 2000). In time, this highly anxious child developed the capacity to express his conflicts symbolically, integrating fragmented aspects of the self, and developing a stronger sense of self and a cohesive whole.

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Chapter 6

Art Therapy with Traumatized Families

P. Gussie Klorer

Traumatic events that affect families can take many forms, including death, war, natural disasters, illness, and violence. Just as an individual's coping skills and personal history help to determine how an individual is going to handle a traumatic event, the family as a unit possesses coping skills and a history that will assist or frustrate its ability to handle a traumatic situation. Not all families suffering from traumatic experiences seek out therapy. For those that do, expressive therapy approaches may be most appropriate because they allow persons at multiple developmental levels to be involved simultaneously, and they can bypass the censors and defenses that may have evolved due to post-traumatic stress responses. Family art therapy can involve even several generations within a family, from the youngest to the oldest, allowing each person an opportunity to express his or her reaction to the traumatic event.

Types of traumas affecting families

The type of trauma will be one factor in determining how to approach the therapy. A single traumatic event will be approached differently from trauma prolonged over many years (Klorer and Malchiodi 2003). Single traumatic events, such as a natural disaster, can affect entire communities simultaneously. Hurricanes, tornadoes, flooding, volcanic eruptions, tsunamis, and other such events can occur with or without warning and will affect the families within the community long after the event.

Acts of violence can also be singular events that will affect families in a community. In New York on 11 September 2001, a single traumatic event affected many families, who were faced with the sudden death of loved ones. Art therapists working near the World Trade Center volunteered many hours to provide children and families opportunities to express their collective

grief (Gonzalez-Dolginko 2002; Levy *et al.* 2003). As part of a family support project, art therapists worked with children and families victimized by the Pentagon bombings (Howie *et al.* 2003). This type of *acute trauma* treatment is very focused on the specific event. Working together with multiple families who have all had the same experience can aid in the recovery process.

Long-term trauma requires a different kind of treatment. An entire community can experience long-term trauma, as evidenced in war-torn countries. There may be not one event, but rather a series of events that causes a collective traumatic reaction that becomes a part of the culture. Approaching treatment for this kind of trauma is especially challenging because of the activation of defenses that have helped the culture and families within it survive. There may be a universal collusion of silence and a reluctance to express feelings when to acknowledge such feelings awakens the ongoing terror. Slater (2003), an art therapist writing from Israel, describes her students as having well-developed coping skills, such as denial and dissociation, as well as fears "for their family and the future, sadness, anger, and need to disconnect as well as a strong connection to this land" (p.2).

Trauma can be intergenerational. Studies of Holocaust survivors suggest that a secondary post-traumatic stress disorder (PTSD) syndrome has been passed from one generation to the next (Baranowsky *et al.* 1998). Transmission occurs through the parents' communication or lack of communication: either an obsessive retelling of the traumatic memories, or complete silence, coupled with strong family ties that promote the child's incorporating the parental reaction (Baranowsky *et al.* 1998). By integrating their parents' experiences, children are able to establish a connection with their parents and maintain family ties.

Abrams (1999) notes that intergenerational trauma is not confined to war experiences. In her review of literature of family systems approaches to treatment, she finds a central clinical feature is the silence that occurs in families surrounding traumatic experiences.

Rather than focusing on art therapy treatment for trauma affecting entire communities (which, as already stated, will suggest a community approach to treatment), this chapter focuses on trauma that is family-specific, either an acute traumatic event or long-term trauma.

Not all tragic events are traumatic. Whether a tragic event becomes a family trauma depends to a large extent on the family's ability to cope, given

their resources, the strength of the parental figures, the family's history, and social and cultural support systems available.

Brief history of family art therapy

Hanna Kwiatkowska (1975, 1978) is most often credited with originating the "family art evaluation," which she describes as happening almost by accident through her work at the National Institute of Mental Health. Family members would visit patients at the hospital, and on occasion would spontaneously participate in the patient's art therapy session. The unexpected material produced during these sessions was so interesting from a clinical standpoint that a more formalized family art therapy evaluation evolved.

Landgarten (1981, 1987) also recognized the potential for art as an assessment tool with families, combining verbal and nonverbal art making tasks in a series. Riley's (1985, 1987, 1988, 1993) numerous contributions furthered the development of art therapy in family work. Many other art therapists have contributed to specific styles of family art therapy, including Arrington's (1991) and Riley's (1985) model of a systematic approach to art therapy, Linesch's (1993) application of a family systems approach to families in crisis, Sobel's (1982) description of strategic family therapy, Roijen's (1991) model for transcultural art therapy, Hoshino's (2003) adaptation of the *addressing* model as a framework for multicultural family art therapy, Riley and Malchiodi's (2003) paradoxical techniques of family art therapy, Belnick's (1993) crisis intervention model for family art therapy, and Wadeson's (1976) multi-family art therapy approach, among others.

Some art therapists define a model of family art therapy based upon a particular population, such as the development of a creative therapy program for families with drug and alcohol problems (Springer *et al.* 1992), family art therapy with sexual abuse issues (Cross 1993), family art therapy with single-parent families (Brook 1993), family art therapy within a deaf system (Horovitz-Darby 1991), the integration of art therapy within the child protection system (Manicom and Boronska 2003), and a description of family art therapy work with political refugees (Kellogg and Volker 1993). In each of these examples, the unique aspects of the population informed the work, and the therapy was designed to meet the specific needs of each group.

Because silence so often becomes a family's way of avoiding the pain of dealing with the trauma, one of the goals of therapy is to give family members ways to express their feelings. The beauty of art therapy is that it

bypasses those censors that families may have adeptly construed. Families that collude in silence are often surprised when the silence is interrupted by an innocently drawn picture. A family that did not know how to express feelings directly may find a way to do so when given an opportunity to draw or paint. Art does not rely upon the use of words for expression, so a family's silence on one level can be maintained, but on another level the feelings can still be expressed.

Art therapy with traumatized families

In family therapy work with traumatized families, there are numerous approaches one might take depending upon theoretical orientation. If possible, the therapist will want to discuss the case initially with the parent(s) without the children, obtain a pre- and post-trauma history of the family, and learn what specific concerns have brought them to seek out therapy at this time. This intake can take place by phone or, preferably, in person. The parents can assist the therapist by describing the troubling event and how they perceive each person in the family has managed it. This meeting is important to establish a bond with the parents, as the therapist and parents must ultimately become team members. At this initial meeting, the therapist is also making an informal assessment of the parents' strengths, which will be vital to the ultimate family work.

Issues to be explored in therapy will vary with each family, but there are some generalities that can be assumed goals in trauma work with families. These include:

1. helping the family to explore individual reactions to the trauma
2. exploring the role that each person plays
3. helping each family member to communicate needs
4. helping the family to find support, either from one another or outside of the family system.

Exploration of individual reactions to the trauma

The first session with the entire family sets a stage for the future work. It might include a formalized family art evaluation, or it may be open-ended to see how the family presents itself. Consoli recommended that the first session include asking each family member to make a picture about "the problem" that brought the family into treatment (Consoli and Klorer 1995). Malchiodi suggests, in cases of acute trauma, that the therapist ask the client

to "Draw what happened" (Malchiodi 2001). In direct approaches such as these, the issue is brought to the forefront from the beginning, and it creates an opportunity to see how the trauma affects the family from each person's perspective.

Even in families that are colluding in silence, there is often one family member that is not subscribing to the set behavior and draws the problem from his or her perspective, irrespective of how it might make others feel. Julie was such a child.

Case example

Julie was only four, but she needed to tell her story over and over again, despite the fact that it made the adults in her life uncomfortable. In her first art therapy session, with a directive that she could draw anything she wanted, she described her picture (Figure 6.1) as she drew it:

> I am drawing my mom. My mom died. She loved me and my sister so much that she wanted to take us with her… She shot me and she shot my sister and I peeked and saw my mom shoot herself. I felt really sad… My mom and my sister turned into ashes and now they are in heaven… I'm drawing my bed and that's me and that's my mom. I'm not going to draw the gun because I don't know what it looks like. That's my sister and she got shot (Klorer 2000, pp.225–226).

When Julie's father joined her in her therapy sessions, she continued to question him directly about why her mom did that, and why she, herself, did not die. Although her father could not possibly answer all of her questions, Julie taught her father to talk about the trauma.

Kwiatkowska (1978) notes that it is often the youngest child in the family who innocently brings the problems to the forefront.

Exploring the role that each person in the family plays

Often, in a family crisis, prescribed roles can become exaggerated. The "organizer" may be even more compelled to keep organizing things, the hyperactive child may become more stimulated by the sudden family changes, the "fixer" may work harder at trying to make everything okay again. Conversely, a traumatic event may cause existing roles to shift, which upsets the normal functioning of the family. When one person changes his or her role in the family, others must make changes in response. For example, a mother who normally functions as the family nurturer is overcome with her

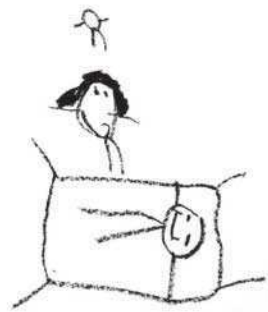

Figure 6.1 Julie's drawing from session 1 (Klorer 2000, p.226)

own grief reaction after the traumatic loss of a child. Her role as nurturer may be relinquished to a daughter. As roles shift, other family members may find themselves in a state of disequilibrium because they no longer have their secure place in the system. Another sibling may reject the daughter's attempts at nurturing, and will act out in a way that forces that mother to become re-involved. All of this upset in roles can cause even more stress for the family.

Case example

In the P. family, 12-year-old David began taking on the responsibilities of his dying father, since he was soon going to be the "man of the house" and felt he needed to protect his family. This was a tremendous burden, as it not only put undue stress on him for the future, but it was preventing him from being able to express his own feelings about the impending death for fear of betraying his weakness. His father had been emotionally abusive for many years, so the entire family was struggling with their conflicted feelings. Such a myriad of complicated feelings could hardly be contained, but none of the children seemed able to approach their feelings directly. Mrs. P. brought the children to family therapy. Each person was asked to draw a family portrait of "today and the future." The following week the therapist met with Mrs. P. alone and all of the

pictures were laid out. The 12-year-old's "future" picture showed himself drawn larger than anyone else and in the central position in the family, with his arm on his mother's shoulder, as if protecting her. Upon observing the picture, Mrs. P. immediately realized the tremendous pressure he was under, and that she had been unconsciously promoting the role for him. She suddenly realized how hard it must be for a 12-year-old to live up to such an unrealistic expectation.

In that one picture so much was communicated without needing to put words on it. The son could probably never have explained the responsibility he was taking on, or have anticipated what he would have to bear in the future. Mrs. P. did not need to be an art therapist to understand the implications of his picture. This small insight was invaluable for Mrs. P. and she and the therapist together devised ways to help her to change her behavior so that her son did not feel a need to take care of her. She could then encourage more age-appropriate responses from her son.

Helping each family member to communicate

Trauma reactions are family-specific, meaning that the same event may affect any two families differently. A random and brutal murder affects the family of the victim for years to come, but one family may grow stronger together as a family afterwards, and another family may be torn apart. Riley (2002) suggests that sometimes the therapist can help clients to accept a traumatic incident as a life-changing event, and reframe it as a catalyst for change to occur. A healthy family with a good support system and well-developed coping mechanisms will be able to use those strengths. The L. family fits this description.

Case example

Mr. L. brought his two young children into therapy because they had witnessed the brutal murder of their mother. Mr. L. noted that several months later the children were displaying anger-management problems and attention-seeking behavior in school and at home, and that these behaviors had not been present before the murder. During the first family session, they were asked to each draw three pictures:

1. a free-choice picture
2. "a picture of your family"

3. a free-choice picture, although "it could be something about your mom."

The children both drew their mother in the family picture, as if nothing had happened, and the father omitted her, which caused the children to speculate that he must not have had room on the paper. When asked why he did not include their mother, Mr. L. said, "Because she is dead." The children immediately began engaging in avoidant behavior. One child put his picture on his head, and said, "It's raining." The other did the same, and soon they were giggling and singing, "It's raining, it's raining!" In the final picture, the one that "could be something about your mom," neither child chose to make anything about their mom. It was apparent that the children needed to find a way to grieve their deceased mother. Family therapy goals were formulated to give the children an opportunity to talk about their memories of their mother and grieve the loss by making a book about her. The book included drawings of positive memories, such as her cooking grilled cheese sandwiches and playing ball with them. It also included what happened the day she was murdered, the funeral, and finally, a picture of the family since the murder. Through this process, the children found a way to conceptualize their mother in their pictures. The solution the children came up with was to put their mother inside of a heart, "because she will always be in our hearts." Mr. L. was very instrumental in this process. His ability to talk about the death directly gave his children permission to explore their own feelings in their own way. The art gave the children a path to do so. This family had a support system of extended family and a close neighborhood and community. With assistance from these external systems, and his own internal strength, Mr. L. was able to help his children.

Helping the family to find support

One often assumes that the parents will be the anchor or organizing strength for the family in a crisis, but this is not always so. When the parents cannot provide emotional strength, it may be necessary for the therapist to seek help through extended family or persons outside of the family.

Case example

Mrs. T. and her children came to therapy because a six-year-old daughter had been murdered by the father. Within several sessions it became apparent that Mrs. T.'s own unresolved grief and depression made it

difficult for her to respond even to her children's basic needs, much less help them to cope with the trauma of hearing their sister being beaten to death in the next room. When the children were talking about their father in one session, the mother was so despondent she could not lift her head from the table. An aunt, the mother's oldest sibling and someone who was used to having a maternal role in the extended family, was invited to be part of the family art therapy for a brief time, so that a support system could be built for both mother and children. The aunt was instrumental in helping the children to express feelings, as prior to her entering therapy the children continually drew "happy" pictures of the entire family, including the dead sister and the father, as if nothing had happened. The aunt was not interested in colluding with this false image, and drew pictures that expressed her own anger that her brother-in-law had murdered her niece. The children then realized that their unexpressed feelings were acceptable, and began drawing a wide range of emotions, including extreme anger and sadness.

After several months of therapy the mother was ready to take on some of the parenting responsibilities, at which time the aunt was eased out of the therapy so that the mother could practice being the head of the family. The therapist began assigning art tasks that put the mother in a leadership role with her children and required the children to go to her for art supplies and structure. Taking the aunt out of the room was necessary because the children automatically turned to her first.

Choreographing these kinds of changes in the course of therapy requires a clear sense of treatment goals, of which the adults and therapist should all be aware so that no one misunderstands the actions being taken. The aunt, who might have misunderstood and felt left out, ended up feeling proud that she was an important factor in bringing about the change. The mother began to experience the sense of being in control, in a very different way from the years she spent living under the dominance of her husband.

Treatment of families with prolonged trauma

In situations of prolonged trauma, treatment will likely be more long-term because the issues involved are more complex and will not be resolved by focusing on a particular incident. Examples of prolonged trauma are situations of extreme domestic violence where the home, which is supposed to be the source of nurturing and protection, is violent and unpredictable. Situations of repeated child abuse and neglect fall into this category. In cases such

as these, there may not be one incident, but rather many smaller incidents that, taken singly, may not appear traumatic at all. For example, a child who gets a spanking for disobeying a known rule is probably not going to hold this one incident as a trauma throughout life. A child who gets repeated whippings without any perceived transgression, and no warning, fairness, or predictability, may develop defenses that help to ward off the psychological ramifications of this kind of treatment. The cumulative effect of repeated incidents can lead to a post-traumatic stress reaction. If abuse is prolonged and occurs during the child's developmental years, it can have long-term effects, including behavioral, cognitive, and possible neurodevelopmental effects (DeBellis 2001; DeBellis and Putman 1994).

Perry (1997) has extensively studied and written about children raised in violent homes. He describes children who live in a state of persistent fear, such that they cannot process and store other information. He describes two differing reactions that a child might develop: either a dissociative response or a hyperarousal response. Those who develop a hyperarousal response are overly reactive, hyper-vigilant, and impulsive because these are skills that will help them to survive in an unpredictable environment (Perry 1997). Studies indicate that the heart rate at rest is much higher in hyperaroused children meeting the criteria for PTSD. With a normal heartbeat per minute (bpm) rate of 84, 85 percent of the children studied had a resting heart rate greater than 94 bpm, and 40 percent had resting rates above 100 bpm (Perry 1994). Working with these children necessitates creative means of interaction. These are active, physical children, and respond to action methods of interaction in therapy, including the use of drama, movement, and tactile art media.

Perry *et al.* (1995) find that the dissociative response activates a different neurobiological response than does the hyperarousal response. Dissociation is seen as an adaptive response when the victim is "more immobile, helpless, or powerless," and when there is "physical injury, pain, or torture" (Perry *et al.* 1995, p.282) involved in the traumatic experience. Dissociation is seen more often in females. In studies of heart rate in PTSD children exhibiting dissociation, it was noted that as the child begins to dissociate, the heart rate hits a plateau and often drops. Behaviors associated with dissociation include "numbing, compliance, avoidance, and restricted affect" (Perry *et al.* 1995, p.281). Understanding the psychobiology of these differing behavioral responses, i.e. hyperarousal and dissociation, will help the therapist to make sense of behavior and reactions that occur in the course of family therapy

focused on long-term trauma (Perry 2001). Males are often misdiagnosed as having attention deficit hyperactivity disorder (ADHD), and present as aggressive, inattentive and noncompliant, whereas females may present as dissociative, depressed, compliant, and undemanding of attention, so they are often overlooked next to their acting-out brothers.

A number of researchers are finding that the overwhelming stress of child maltreatment is associated with adverse brain development. DeBellis (2001; DeBellis *et al.* 1999) used Magnetic Resonance Imaging (MRI) technology to compare brain development in medically healthy, clinically referred children with chronic PTSD with that of non-traumatized healthy control subjects. They found that the maltreated children had smaller MRI-based brain structural measures of intracranial volumes than did the non-abused controls. PTSD cluster symptoms of intrusive thoughts, avoidance, hyperarousal, or dissociation correlated negatively with intracranial volume. The study suggests neurobiological consequences of trauma. The earlier during childhood the abuse occurs, the more severe the effects on intracranial volumes. Additionally, a negative correlation of intracranial volumes with abuse duration suggests that childhood maltreatment may have a cumulative effect on adverse influences of brain development (DeBellis 2001; DeBellis *et al.* 1999).

When working with families traumatized over a period of time, one should take into account that years of violence will also affect how the memories are stored in the brain. Schiffer, Teicher, and Papanicolaou's 1995 study of hemispheric activity of the brain in subjects with a history of trauma showed significant left-dominant asymmetry during neutral memories, which shifted markedly to the right when patients thought about an unpleasant memory. The implications of this research are that traumatic memories may be stored in the right cerebral hemisphere, which would make verbal declarative memory of the trauma more difficult (Schiffer *et al.* 1995).

Other studies show that exposure to violence or trauma alters the developing brain by altering neurodevelopmental processes. Rauch and colleagues (1996) used positron emission tomography (PET) scanning to study patients suffering from PTSD. When focusing on their own traumatic memories, these individuals showed heightened brain activity in their right amygdala and associated areas of the temporal and frontal cortex, as well as in the right visual cortex. At the same time, the area concerned with language in the left hemisphere was "turned off." This suggests that the

tendency of PTSD patients to re-experience emotions as physical states rather than as verbal memories has a neurobiological explanation (Glaser 2000; Rauch *et al.* 1996).

All of this research suggests that families that appear to be colluding in silence may actually have difficulty accessing verbal memories. In situations of prolonged trauma, nonverbal approaches to treatment will be most appropriate because the memories may be stored in nonverbal portions of the brain and are not necessarily activated as declarative verbal memories. As some of the examples in this chapter attest, one can activate feelings through art, with the understanding that the art will be the primary means of communication, independent of verbal processing.

Staying with the family's silence, and respecting it as an understandable outcome of prolonged trauma, can be difficult for many therapists because they operate under the principle that talking about the trauma is one of the goals of therapy. If one makes a small word change in this goal, it can become more achievable, as seen in the following example.

Goal: The clients will begin to talk about the trauma.

Goal: The clients will begin to express feelings about the trauma.

In the first goal above, the therapist has decided the mode of expression that is most valued, whereas in the second, the client determines this. This is one of the most important differences between expressive arts therapy and traditional verbal therapy, and it is why expressive therapy can be so effective in trauma work, since it bypasses the need for verbalization.

Case example

Tasha and two of her siblings attended family therapy without their parents because their parents were the source of the trauma. Tasha did not want to be in therapy, and made her point in the first session, where she closed her eyes for the entire 50 minutes. From her social worker, the therapist learned that the home was a scene of prolonged domestic violence. The parents had fought for years, abused the children both emotionally and physically, got divorced, and both lost custody due to inappropriate parenting. The children were in foster care and their future was uncertain. Their mother had just died of cancer, and their father, who came in and out of their lives at his convenience, told the children that now he had cancer, and even shaved his head so that they would believe he was having chemotherapy. Tasha, aged 12 and the oldest of the five siblings, did not believe him and was trying to emotionally separate

herself, but her feelings encompassed years of traumatic memories, and were impossible for her to put into words. In most therapy sessions, she said nothing. If asked, things were "Fine."

The therapist suggested that the children make "feelings boxes," a place where all of the inside feelings about their dad could be stored. Tasha normally did not like any of the art directives that were suggested by the therapist, but this one seemed to challenge her. She chose a box about five inches square, and first wrote notes on pieces of paper, which she showed to no one, and put inside of the box. Then she secured the box so that it could not be opened, by gluing it tightly shut. Then she taped it, using clear tape, masking tape, and duct tape. In the next few weeks, she continued to work on the box. She said she wanted the box to hurt when you looked at it, so she covered it with sandpaper. Finally, she secured nails all around the top and sides of the box, so that it could not be picked up. Tasha felt very satisfied at the completion of the box, but she had a fear that somehow her father would confiscate it and know her feelings, so she kept it in the therapist's office, where she knew it would be safe. Tasha did not have to tell the therapist what was inside of the box. The therapy work happened because she found a way to express it for herself. The therapist must be secure in the knowledge that he or she does not need to be privy to what is inside, as long as the client has been able to express it to her own satisfaction. In Tasha's case, what was unsaid did not need to be verbalized, once it was expressed.

A second example is seen in the case of Peter, aged seven, and five-year-old Ellen, two siblings seen in family therapy without their parents.

Case example

The children were in a foster home after having been removed from their mother's care due to her inappropriate discipline practices and sexual abuse. The children were witnesses and participants in multiple layers of incestuous behavior, as exemplified when Peter announced to the therapist that his mother had told him that he could have sex with his five-year-old sister any time he wanted. Peter vehemently denied any abuse throughout several years of therapy. Both children repeatedly expressed a wish to go home. Peter's art, however, revealed a whole different perception of his home life. In the first art therapy session the children were told that they could draw anything they wanted. "Anything?" Peter asked incredulously. After repeated assurances, he said, "Can I draw

the vampire that kills my mom?" Peter's media of choice was sculpture, as he responded to the tactile nature of found objects and materials and manipulated them into structures that defined a world much different from the one he projected consciously.

One day Peter created a holiday living room scene, a diorama made from a cardboard box. He carefully added a braided rug, which he made from yarn, drew little pictures to hang on the walls, and created a Christmas tree in the corner of the room, festively decorated (Figure 6.2). He then added a chain to the tree, which was attached to the walls of the room, "So nobody can just come in and steal the tree." To the outside of the house he added scores of toothpicks, protruding out of the exterior walls in a way that appeared both aggressive and defensive. This, too, appeared to be a way to protect the tree inside the house. For a child such as Peter, articulating the pain of living in his own home was impossible, and many Christmases had been "stolen" from him, so using this metaphor appeared to be a way that he could satisfy the memories in the brain—both the part he was willing to talk about and the part that he could not talk about.

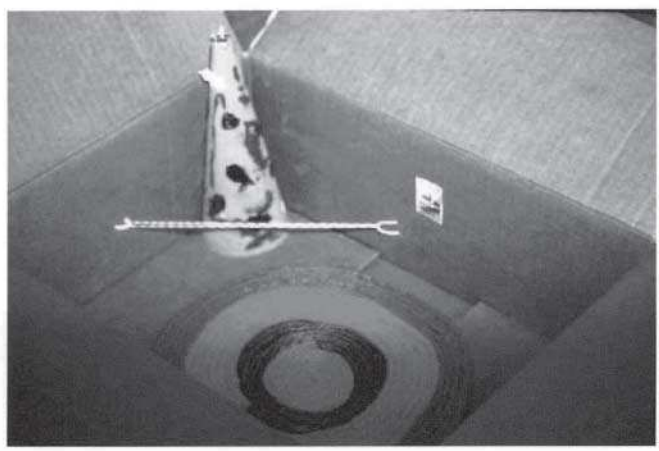

Figure 6.2 Peter's Christmas tree

Termination of family treatment

The decision to terminate therapy should be made together, between the therapist and family members. In situations of acute trauma, the therapy is likely to be short-term, and will be completed when family members feel that they are ready to move on in their lives. There may be a reduction in symptoms of post-traumatic stress, such as a decrease in nightmares for young children, decreased exhibition of anxiety, a feeling that daily living has become more manageable and that things are getting back to "normal."

Termination should include a review of the expressive work that has been accomplished, returning to the clients all art work that they would like to keep, and an invitation to return to therapy at any time the need arises. Although many families with acute trauma do not ever need to see a therapist again, there are occasions when a family member will have a delayed reaction to trauma, particularly at adolescence, and sometimes revisiting therapy allows that last piece to be worked through at a later time, when the young person is more ready.

In situations of prolonged trauma, the decision of when to terminate therapy is often less clear. Treatment goals in such cases are usually indicative of more long-term work. When the family's living situation has been made safe, when symptoms of post-traumatic stress have abated, when the children are ready to just be children for a while—all of these are indicators that at the very least a treatment break is in order. For those who have lived with long-term trauma, a return to therapy at a later developmental stage, certainly at adolescence or as the client approaches adulthood, is often suggested.

Whether one is working with acute or long-term trauma with families, art therapy will provide a means of communication and interaction that will be invaluable to the work. Families will find a meeting ground, a way to express what can be said and what remains unsaid. The key to expressive work with traumatized families is to respect the power of the art to do the work. It sounds so simple. It is easy to forget that this is what expressive therapists do best.

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Chapter 7

Songs of the Self
Vocal Psychotherapy for Adults Traumatized as Children

Diane Austin

I was singing
And I didn't care what it sounded like
I was singing
And I felt alive
Like estranged lovers finding each other
After many years apart
My head and my heart
Embraced again
And long forgotten sounds rained
Softly around me
While fear danced through my body
And emerged as joy.

Diane Austin

Any experience that causes an infant or child unbearable psychic pain and anxiety is traumatic. Traumatic experiences encompass a wide range of occurrences, from the horrors of sexual and physical abuse to the more cumulative traumas of unmet dependency needs, inadequate nurturing and interruptions of the attachment bond. Common to all of these experiences is the rupture to the integrity of the self and the feelings of confusion, helplessness, and terror that this rupture evokes (Terr 1990; Kalsched 1996). When this rupture occurs before a coherent ego and its defenses have been adequately formed, the intense affects are too overwhelming to be metabolized and processed normally, hence the devastating effects on the trauma-

tized person's body, mind, and spirit (Herman 1992; Kalsched 1996). The traumatic experience, as well as the meaning attached to it, critically affects an individual's experience of self and her ability to engage in an intimate relationship (Ulman and Brothers 1988). Trusting another person is difficult, for at the root of developmental trauma, whether it involves sexual or physical abuse or lack of attunement, lie feelings of betrayal and psychic abandonment (Austin 2001; Bowlby 1969, 1973; Carnes 1997). Intimacy can feel dangerous for clients with histories of early trauma because close relationships can trigger intense fears of dependency, engulfment, or abandonment.

Traumatized clients often alternate between a state of feeling overwhelmed and flooded by intense emotions connected to the re-experiencing of the trauma and a state of "shut-down," a psychic numbing, which can include avoidance of people, places, and things that might trigger associations that bring on intolerable anxiety or panic. Primitive defenses like denial and dissociation protect the fragile self from annihilation but also affect the integrity of the personality. Severely dissociated clients experience the self as enfeebled, fragmented, or lacking in continuity (van der Kolk 1987; Levine 1997).

Abused or neglected children usually assume responsibility for the abuse they suffered. They blame themselves and often carry a sense that they are "rotten," "bad," or "cursed." They are frequently filled with shame and self-contempt that results in self-destructive acting out. It is psychologically easier to blame themselves because then they have an illusion of control over the situation, which acts as a defense against despair, and the terrors of abandonment feelings. As Kathy put it, "I used to think if I tried harder, got better grades, and wasn't a burden, my mother would finally love me."

It is also incredibly difficult to accept that the person you depend on for your very life is abusing you. Children need to preserve a good image of at least one parent in order to feel some small bit of safety. Fairbairn (1943) believes these children internalize bad parental objects as a defense in an unconscious attempt to control them. These outer perpetrators are now internalized and retain their power in the inner world of the abused child. Davies and Frawley (1994) describe work with sexual abuse survivors and how they struggle with the "possession" of their patients "by internalized abusive objects to whom the patient remains tenaciously attached" (p.22). Later these adult children often re-enact their traumas by picking sexual partners or friends who abuse or abandon them and, even more significantly, they neglect and abandon themselves.

I find change is possible when clients can gradually remember and experience on an emotional, psychological, and physical level what really happened to them and have their experiences validated by the therapist. Then they can put words and a name to what happened, make meaning out of the experience, and finally understand that it wasn't their fault. They are not bad or unlovable. Their parents or caregivers were severely wounded and/or lacked adequate parenting skills. Once this knowledge is integrated, these clients can grieve their losses and move forward with their lives.

Vocal psychotherapy

I define "vocal psychotherapy" as the use of the voice, improvisation, song, and dialogue within an analytic orientation to promote intra psychic and interpersonal change. Vocal psychotherapy is in-depth music psychotherapy with an emphasis on the voice: speaking, sounding, and singing.

Recovering from trauma requires re-inhabiting the body and healing the splits between body, mind, and spirit. Some traumatized clients are extremely emotional but have no words or cognitive explanation for their intense affect. Others can tell you all the details of their sexual or physical abuse but remain totally disconnected from any feelings.

Voice work is restorative for many reasons. The first step in reconnecting to the body-self is learning to breathe deeply. On a physiological level, sounding and singing facilitate deep breathing. In order to sustain tones one has to take in more air, thus expanding the belly, diaphragm, and the whole torso, and then has to fully release the breath in order to continue the process. Breath is the life force that connects the mind, body, and spirit. Deep breathing slows the heart rate and calms and nurtures the nervous system, stilling the body, quieting the mind, and creating an experience of groundedness. The result is relaxation, a beneficial state for everyone, but crucial for someone experiencing panic or extreme anxiety (Austin 2001, 2002).

There is reciprocity between the physiological and psychological effects of breathing. We can control our feeling by restricting the intake and release of breath. We can let go of anxiety and tension by slowly exhaling and take in new energy when we inhale. When working with clients who are anxious or dissociated, I find it useful to begin with breathing exercises. I sometimes offer clients a suggestion to breathe in something they need and exhale something they don't need, or wish to let go of. As we continue breathing I suggest they allow the exhalation to become a sigh, a groan, or a moan, and then eventually a sustained tone (Austin 2004).

Toning, the conscious use of sustained vowel sounds for the purpose of restoring the body's balance, is also very effective in resonating with specific areas of the body to relieve emotional and physical stress and tension (Campbell 1989; Goldman 1992; Keyes 1973). Toning and singing are neuromuscular activities, and muscular patterns are closely linked to psychological patterns and emotional response (Newham 1998). When we tone or sing we produce internally resonating vibrations that break up and release blockages of energy, thus enabling a natural flow of vitality and a state of equilibrium to return to the body. These benefits are particularly important to traumatized clients who have frozen, numbed-off areas in the body that hold traumatic memories and experiences. This residue of unresolved, undischarged energy gets trapped in the nervous system and creates many of the debilitating symptoms associated with trauma (Levine 1997).

Children who are raised in an atmosphere of fear, hostility, violence, or neglect have been silenced. Sometimes they withdraw into an imaginary world and find safety there. These are often the quiet, "good" children who adopt a compliant, adaptive self and forfeit their voices and needs out of self-protection. Sometimes the silence is selective. Certain feelings are allowed, others are unsafe to voice. One client I work with, Beth, was told, "If you cry again, I'll give you something to cry about!" Not only is it extremely difficult for her to cry, but when we began working she spoke in a barely audible voice and raced through her sentences as if someone was chasing her.

Sometimes, as needs and feelings remain unmet, the voice becomes tight and forced, breathy and undefined, inaudible or simply false. Some traumatized clients have speaking or singing voices that are trained and lovely to listen to but are not authentic. In essence, the traumatized person often survives by forfeiting her own voice. Singing enables traumatized clients to recover or perhaps find their voices for the first time.

Case example

Lynn, an anorexic client who liked to sing, needed a lot of structure to feel safe. We began by singing scales and then simple repetitive melodies with lyrics that were affirmations such as, "I'm doing the best that I can do." One day, while we were singing together, Lynn felt chills run up and down her body. At first these sensations upset her. They made her aware that she *had* a body. Gradually, however, she came to enjoy the sound of

her voice, as it grew stronger. She felt more alive and less empty. Singing felt empowering and became a way for her to be in her body and feel better about herself.

Songs

Songs provide traumatized clients with a container that has a beginning, a middle, and an end. Within the safety of a song's structure, clients can often access and express intense feelings. The musical elements of the song, rhythm, melody, and harmony, have aesthetic and emotional significance that the client may or may not be aware of. The lyrics can also evoke images, memories, associations, and feelings. The song can be a catalyst for buried emotions while also providing a container for them.

When clients choose a song they are often revealing something about their emotional, psychological, or spiritual state. A presenting song can be like a presenting dream in that it can foreshadow the main issues that will emerge in the treatment process (Austin 1993). Songs that spontaneously arise in the client's mind during sessions are also valuable clues to unconscious issues and dynamics such as transference reactions (Diaz de Chumaceiro 1992). Thus, songs can be useful in assessment.

When working with traumatized clients, I sometimes sing songs to them when they are crying or need extra support or containment. In several instances, clients have requested a tape recording of my rendering of a song I have sung to them during a session. They have reported back to me that the tape has been effective in moments of anxiety or grief. As Sue put it, "I heard your voice and I felt you were here with me… It made me feel safer and made it easier to get through the night."

Vocal improvisation

Vocal improvisation is a form of play. Improvisation comes from a natural impulse and when that impulse is not blocked, but is allowed free expression through vocal and musical play, spontaneity is released (Spolin 1963). Why is this so important? Many adults traumatized as children are "frozen," disconnected from their natural instincts and unable to react spontaneously. Their spontaneous impulses become short-circuited by secondary, inhibiting ones, the early internalized messages from parents and significant people in their lives. These secondary impulses become habitual and familiar, and

what is familiar feels safe. Natural impulses become difficult to connect with and hard to trust because they feel unfamiliar and unknown.

Like Beth, who was not allowed to cry, and Paul, whose natural enthusiasm was squashed by the constant messages he received to "Keep quiet! Your father is in a bad mood," many traumatized clients do not feel safe enough to play. Play evokes spontaneity, and spontaneity becomes associated with the fear of loss of control and judgment.

The immediacy of vocal improvisation can provide clients with a musical encounter in the here-and-now that is physical, emotional, and spiritual. It is possible for clients to be directly involved on a sensory and feeling level with another (the therapist) who is also fully present and available for a relationship. Clients can be companioned and feel safe enough to freely experiment and play with sounds, with the possibility of transcending previous creative limitations. Spontaneity returns as clients can allow for the natural flow of impulses and express themselves from an authentic center of being. Healing can occur as clients gain enough confidence to let go of old frames of reference and ready-made responses and allow for the unexpected, the instantaneous and new concepts of the self to emerge.

Resourcing

"Resourcing" is a term used in trauma work (Hudgins and Kiesler 1987; Levine 1997) and refers to the process of helping clients connect to inner and outer sources of support and strength. Clients may need resourcing at the beginning of the session in order to be more present in their bodies before talking, playing, or singing. Sitting quietly and breathing together can help clients feel less anxious and more grounded. This is a simple technique that clients can use on their own when they feel panicky or frightened. The resource is within them, and realizing that they have the ability to calm and nurture themselves is empowering.

Many clients have inner resources they are unaware of and need help identifying. I will sometimes ask, "What helped you survive your childhood?" or "What inner qualities or strengths do you possess that helped you get where you are today?" These questions provoke introspection and self-examination. When clients answer "my sense of humor," "my anger," "my courage," etc, I then ask if they can put that quality into a sound and movement. If they can, I mirror them and we repeat this several times. Sometimes it is easier or preferable for them to think of a song that conveys this quality and then they, or we, will sing it. Sometimes, I will invite them to improvise vocally over

two or three chords, about the quality, to the quality, or as the quality. For example, Josh sang as his "determination." Some of his lyrics were, "I won't let him stop me from growing… I don't have to be a f—— up like you." Embodying the quality and hearing the words out loud helps clients to become more aware of strengths they possess, and aid in the integration of these strengths.

Clients also have outer resources they may or may not be aware of that fall into three categories: places, people (or animals, objects), and spiritual support. I will, for example, ask clients if there is a place where they felt safe as a child and/or a place where they feel safe now. I will ask them to describe it in detail and imagine that they are there. Again, I might suggest they express this safe place in a sound and movement, a song, or an improvisation. Other options are to write a song together or to hold this place somewhere in the body and find a tone that resonates with that area. I will then support them by joining in the toning.

I work similarly with the other two categories. "Was there a person you could go to when you needed help or felt unsafe?" If the answer is "no," which is not uncommon with traumatized clients, I ask if there was an animal (a pet) or a special toy.

Case example

One client I work with, Sara, has a doll she received from her grandmother when she was two years old. She is now 35 and still finds comfort in talking to this special doll when she is deeply depressed or anxious. She sometimes brings the doll to therapy sessions when she is feeling regressed. When Sara is confused or unsure about what she feels or thinks, I will sometimes ask her doll for help. The doll clearly represents a dissociated aspect of Sara who is strong and wise. Sara often sings about the doll, to the doll, or as the doll. The singing helps her connect with this split-off part of herself, relate to it, and work towards integrating it.

When exploring the third category, I usually ask clients if they have some kind of a higher power, a term used in Alcoholics Anonymous and other twelve-step groups to describe "God" or a belief in something transcendent, religious, or spiritual. Again, we then take this source of support into the music. We tone, sing songs, improvise music, or listen to music that evokes the spiritual dimension of the client's life. All of these outer resources are

potential inner resources that with time clients can access in difficult moments and draw strength from.

Vocal holding techniques

"Vocal holding techniques" is the term for a method of vocal improvisation I developed and codified. It involves the intentional use of two chords in combination with the therapist's voice in order to create a stable and consistent musical container that facilitates nonverbal, improvised singing within the client–therapist relationship. This method, because it provides a predictable structure and a strong vocal connection with the therapist, is useful for clients who are afraid or unused to improvising. Vocal holding techniques are also very effective with adults who suffer from early injuries to the self and require a therapeutic regression. The simplicity of the music and the hypnotic repetition of the two chords with the rocking, rhythmic motion and the singing of single syllables can produce an altered state and easy access to unconscious memories, so that they can be processed and integrated into consciousness. Vocal holding techniques enable the clients and the therapist to contact and communicate with dissociated parts of the self that have been split off and suspended in time due to traumatic occurrences. Clients can then re-experience these events companioned by the therapist, with the potential for a reparative experience. Developmental arrests can be repaired and the vital energy contained in dissociated aspects of the self can be made available to the ego and utilized by the present-day personality (Austin 1996, 1998, 1999, 2001, 2002).

Vocal holding techniques are especially useful in working through traumatic ruptures in the mother–child relationship and empathic failures at crucial developmental junctures. These techniques facilitate regression, and extensive regression is often required in working with traumatized clients. Verbal interpretation and illumination of psychic conflict is of minimal value until the link between self and other is rebuilt and the client's capacity for relationship is restored. The containing functions of the therapist and nonverbal acceptance and management of regression is paramount with this population (Balint 1979; Davies and Frawley 1994; Herman 1992; Hegeman 1995).

Improvised singing seems ideally suited for this reparative work. The voice is a primary source of connection between mother and child. The human ear is fully functional from four-and-a-half months before we are born. The sounds we hear in the womb, our mother's breathing, heartbeat,

and especially her voice, fire electrical charges into our cortex and stimulate our brains. This stimulation aids in the development of the brain and the central nervous system. The mother's voice is like a cord that connects the child to his life source and provides the positive intrauterine and post-birth experiences so essential in fostering the child's ability to bond with others (Minson 1992). The vocal interaction in speech and song between infant and mother is critical to the child's continuing development (Newham 1998).

Vocal holding techniques are not meant to be a prescription or recipe and are not necessarily used in the following order. For the sake of clarity, however, I will describe the process as it appears to complement the developmental stages. As with any therapeutic intervention, however, the client's history, diagnosis, transference reactions, and unique personality and needs should determine the approach taken to accomplish therapeutic goals.

In the initial "vocal holding" phase the client and I sing in unison. Singing together on the same notes can promote the emergence of a symbiotic kind of transference and countertransference. This was important for Marie, who never had a satisfactory experience of merging with an emotionally present, attuned mother. In our initial vocal holding experiences, Marie preferred singing in unison with me. When I moved to another note to harmonize with her, she followed me. Over time, she allowed me to leave her note and sing in harmony with her and gradually she began to explore more of her vocal range and create more expressive melodies.

The second stage, harmonizing, creates the opportunity for the client to experience a sense of being separate, yet in relationship. Singing in unison or harmony can be very soothing and useful when clients need comforting or closure at the end of an emotional session. It is also a way to encourage clients to improvise. They may feel safer because they are not alone or exposed and they can draw on the therapist's voice for support.

Mirroring occurs when a client sings her own melodic line and I respond by repeating the client's melody back to her. I often used mirroring with Marie to support her in finding, strengthening, and staying grounded in her authentic voice (for example, when she musically confronted her mother). Mirroring also helped her to hear and accept new parts of her personality, like the happy child, when they emerged. The musical reflection provides encouragement and validation. Grounding, when I sing the tone or root of the chords, often provided a base for Marie's vocalizations later in the

process. She would improvise freely and return to "home base" whenever she wanted to check in.

This musical intervention is reminiscent of a pattern of interaction between the child and the mother that occurs when the child begins to move away from the mother to explore the environment. The mother must be able to perceive and respond with approval to the child's nonverbal cues as the child moves from and to the mother. This attunement and matching encourages and supports the individuation process (Mahler, Pine, and Bergman 1975). Without the mother's approval and availability, the stages of separation and individuation become associated with object loss.

Vocal holding techniques are introduced into the music psychotherapy session in various ways. With clients who are unused to improvising, I might explain the method in detail. Usually, however, I give a minimal description and then I invite the client to pick two chords. With clients who have little or no knowledge of chord structure, I usually play examples of different chord combinations (major, minor, suspended, etc.) and ask for their preference (Austin 1999). I then invite clients to begin singing, using any sound they want. If they are anxious I might begin, usually on an open vowel sound. Giving choices and working collaboratively empowers the client and helps to create a safe therapeutic environment.

Breathing together begins the process of vocal attunement that continues as I attempt to match the client's vocal quality, dynamics, tempo, and phrasing. Being present to the client as an empathic companion may also involve matching physical movements (for example, rocking together) and making eye contact if the client initiates it.

This musical approach tends to promote positive transference and countertransference reactions that are essential in repairing the link between self and other and restoring the client's capacity to bond with a positive maternal figure and renegotiate critical developmental junctures. When the music/relational container feels trustworthy enough, traumatized clients can gain access to dissociated feelings, memories, and images from the unconscious so that they can gradually be experienced, understood, and integrated.

Case example

"Hi Diane," Cindy greets me with a smile as she enters the room. She puts her bags on the floor, comes over to the piano and sits on the bench next

to my chair. She seems to have thought about what she needs from today's session. She makes eye contact with me as she says, "I have a sense that there is a huge scream stuck in my throat." She had a dream about this stifled scream and wants to release it. She feels it is connected to the sexual abuse she experienced as a child. As she talks, I notice that she speaks slowly and sighs occasionally. Her voice lacks energy and the melody of her sentences often descends at the end. She sounds slightly depressed to me.

We have spent several sessions taking her history. I feel it is important for her to tell her story slowly, with time for us to interact and relate to the material and each other. I have learned through experience that very wounded people can become traumatized when they have to condense a lifetime of painful and/or intense memories into an hour-long therapy session. Going slowly helps them to digest the feelings that emerge.

I ask Cindy if she feels like singing. I want to get a sense of her music and her singing voice. I also sense that her words are disconnected from her feelings. I think singing can offer her a way to access and express some of the emotions contained in the memories and incidents she has been describing.

Cindy has many strengths and resources. Still, I am wary of her enthusiasm to "get the scream out." It seems too soon in the process to work that deeply. I offer her choices. "We could tone, sing a song, or improvise over two chords." She says she'd like to improvise over the chords. "I'm a little afraid but…yeah, I'd like to try that."

I ask her what she is afraid of and she says she's not sure: "Probably just the unknown of it…maybe the closeness." I ask her what two chords she would like. She says, "I like the key of D flat." I begin playing D flat to G flat/B flat, medium tempo and dynamics. Cindy likes this combination. I suggest that we begin by breathing together several times and that whenever she feels ready she can begin singing sounds or words.

I feel curious. What will it be like to sing together? She sighs, we sing "ah" in unison on an F then we move to a B flat. I sing in unison to support her vocally and emotionally. I am also feeling out her response to the unison to get a sense of what she needs and what she feels comfortable with. Is unison comforting, supportive, or too merged? Does she need more tension, more distance, more differentiation?

She begins to sing softly, "m-m-m," then starts growling, increasing the dynamics, range, and intensity of her sounds. I sing in unison with her, then mirror (repeat) her sounds and at times hold the tonic to ground

her vocalizations. My intention is to accompany her on this journey so that she feels supported and met in the music.

She begins to sing long, legato phrases on "ah." She goes rapidly up the scale like a siren and then switches to intricate rhythmic patterns, syncopated "da da, ba da," repetitive, drum-like sounds on E flat. She seems to be exploring her range, different rhythms, vocal qualities, and emotional states. I notice that she has a well-trained voice with a deep, rich quality and a wide vocal range. At times it is difficult to follow her. I feel challenged yet determined to stay with her. I am living in the unknown of the moment with her and I don't know where we are going.

Cindy begins singing louder, than laughs and returns to the "m-m-m" sound in the lower part of her range. She builds on a simple melodic line of repeated thirds and fourths and works her way up the scale, ending with a scream-like "ahhh." She then slides down the scale and laughs loudly. She returns to "m-m-m," now singing softly and rocking herself back and forth. I notice that she is changing dynamics, phrasing, pitch, and vocal qualities rapidly. I am trying to stay with her and meet her screams, laughter, and gentle melodies. I change the chords slightly, adding some dissonant notes, and play the piano louder to support her screams and growls.

I rock back and forth with her and attune myself to her breathing, phrasing, dynamics, and vocal quality. I notice how similar our voices sound. She stops singing but continues rocking back and forth and breathing deeply. I continue to sing and rock back and forth with her. I would usually stop singing when the client stops, but there is something in the way that she is rocking herself that makes me feel like continuing to sing, probably the sense that she needs this vocal holding and containment. I feel I am soothing her. I sing "ooo" to a melodic refrain built around A flat, B flat, D flat, A flat for a few minutes, then slow down the tempo and gradually bring the music to a close.

Cindy breaks the silence quickly. She looks at me and says, "I sang longer than I thought I would but I didn't get the scream out." We continue processing the music and Cindy says she feels in touch with her "inner child." She starts talking quickly about her childhood. I sense she is disconnected from her feelings. I ask her what she is experiencing in her body. She says she feels some pain in her stomach. I suggest we "hang out" with the sensation. After a few moments I again ask what she is experiencing. She says, "The pain has grief and fear in it."

I ask Cindy to breathe into the pain and try to stay connected to her body. I breathe with her. She begins to cry. She says, "I can see my little girl…she is scared." I ask Cindy if there is anything she wants to say to

her. She says, "It's okay to be afraid." I then add, "You don't have to scream today. We have plenty of time." Cindy looks at me and says, "I guess I was pushing her too fast but we have time." "Yes," I reply, "lots and lots of time."

Free associative singing

"Free associative singing" is the term I use to describe a technique that can be implemented when words enter the vocal holding process. It is similar to Freud's technique of free association (1913, 1938) in that clients are encouraged to verbalize whatever comes into their head with the expectation that by doing so, they will come into contact with unconscious images, memories, and associated feelings. It differs from Freud's technique in that the client is singing instead of speaking, but more significantly, the therapist is also singing and contributing to the musical stream of consciousness by making active *verbal* and musical interventions. The accompaniment (two-chord holding pattern or repetitive riff) and my singing continue to contain the client's process, but the emphasis now is not only on "holding" the client's emerging self and psychic contents, but on creating momentum through the music and the lyrics that will propel the improvisation and the therapeutic process forward. The progression to words and the more active role I take generally promote a greater differentiation between the client and myself. When I begin questioning, reframing, and adding my own words to the improvisational dyad, the transference and countertransference can become more complex. The client may experience me not only as the "good-enough" mother, but in other roles as well (figures from the client's interpersonal and intra-psychic world).

In its simplest form "free associative singing" involves the client singing a word or phrase and my mirroring or repeating the words and melody back to her. The vocal holding techniques of singing in unison, harmonizing, and grounding add additional support. With the movement to words there is often a need for more variations in the music. The two chords remain the basis for the musical improvisation, but changes in the client's feeling states and emotional intensity often require a broader musical palette. Variations in dynamics, tempo, voicing, arpeggiation, rhythm, accents, rests, alternate chord substitutions and chord extensions (adding 7ths, 9ths, 11ths, 13ths) enable me to reflect and support the client's experience. In this way, I use not only my voice and the lyrics but also the music to deepen the vocal improvisation and the therapeutic process.

Throughout the improvisation I am making critical decisions about when, how, and what to sing with the client. This is especially true when I move beyond simply mirroring the client's lyrics and music and begin to vocally provide empathic reflection, use repetition to emphasize important words, and make gentle interpretations by singing thoughts and feelings clients may be having but are not yet voicing. By taking a more active role in musically facilitating the therapeutic process with the singing of words, I can help clients understand and make meaning out of what they are experiencing in the present and what they experienced in the past and how these events affected their sense of self. Old, unhealthy self-concepts can be replaced by new, realistic ones resulting in self-acceptance and increased self-esteem.

I recently realized that a technique I find invaluable and that I had referred to as an "alter-ego" (Austin 1998, 1999), was actually a musical version of the psychodramatic "double." The "double" speaks in the first person, using "I," and expresses feelings and thoughts the client might be having but either has no words for or is unaware of. The words can be protested or confirmed by the client. Hearing the words spoken aloud supports the client and enables him to name the feelings, express them, and process and integrate previously repressed or dissociated emotions (Dayton 1994, 1997).

When I "double," I sing as the inner voice of the client and use the first person ("I"). Drawing on induced countertransference, empathy, intuition, as well as knowledge of the client's history, I give voice to feelings and thoughts the client may be experiencing but is not yet singing, perhaps because the feelings and thoughts are uncomfortable, unconscious, or the client has no words for, or ability to conceptualize, the experience. When the doubling is not accurate it still moves the process along, as clients can change the words to fit their truth. When it is accurate, it provides clients with an experience of being truly seen and understood. It also encourages a bond between client and therapist, and over time strengthens the client's sense of self.

This intervention is especially useful for clients working to integrate thinking and feeling or a mind–body split. Doubling offers an effective way to breathe feelings into words and supply words for feelings. In addition, the naming or labeling of unprocessed trauma material can aid in preventing uncontrolled regression and retraumatization (Hudgins and Keisler 1987).

Case example: Cindy, continued

Cindy feels ready to confront her perpetrator, her uncle. We spend extra time breathing together until she feels grounded in her body. I ask her what chords she would like and she replies, "Something in A minor, maybe something modal." I begin playing A minor to D minor, medium tempo and dynamics. Cindy begins singing.

Cindy: Okay, I'm ready. He is sitting on the bed looking out the window. He knows, he knows why we're coming. He's very sad.

Diane: He's very sad.

Cindy: He's very ashamed.

Diane: He's very ashamed.

Cindy: We walk in—Mommy takes my hand. [I realize that she is singing as her little girl accompanied by her adult self-mommy, and me.]

Cindy: And they're both crying.

Diane: They're both crying, they're both crying, Mommy takes my hand, they're both crying—he knows what he's done—he feels so ashamed.

Cindy: I know you're very sad—I know that you were hurt, but you can't do this anymore—not to my little girl, not to my little girl. [Cindy is now singing as her adult self mothering her younger self.]

(I change my piano accompaniment. It is very rhythmic with a strong moving bass line. I am playing parallel 5ths so there is lots of dissonance. The chords are modal 7ths, 9ths, 11ths, and 13ths.)

Cindy/Diane: Not to my little girl—NO, NO, NO!

Diane: NO!

Cindy: Keep your hands off of her!

Diane: Keep your hands off of her!

(The music supports the intensity of our singing.)

Cindy: You will have to answer to me—I'm taking care of her now! You keep your hands off, I'm warning you—I'll make your life miserable. I'm not kidding.

Diane: He can see your power. He knows you're not kidding. He can see it in your eyes.

(I am playing loudly to match her singing. The polyrhythms and syncopation support and encourage the expression of her anger.)

Cindy: He can see my power.

Diane: He can see your power.

Cindy: He knows he's gotta feel—this pain and sadness for a long time, he's gotta feel—remember what he did to me—he's gotta feel the pain—he's gotta feel what he did to us, so he's feeling it and he's hurting, hurting, hurting, hurting, hurting, hurting inside—and that's the only way he's gonna face himself. He's gotta face what he did, he's gotta make retribution on his soul—and that's alright with me because I carry all my burdens by myself—I don't ask anybody to let me off the hook—so you go ahead and feel it, you go ahead and feel it, you go ahead and feel what it felt like to have my uncle treat me like I was his lover—I'm not carrying it for you—it's yours—I'm gonna give you back this basket—I see it hurts your shoulders, but that's OK—it's yours.

Diane: It's yours, it's yours, I'm gonna give it back to you. It's not my burden.

Cindy: It's not my burden.

Cindy/Diane: Not, not, not, not, not, not—I wanna go on and be a woman.

(We are singing in unison and harmony)

Diane: On and be a woman, I wanna go on.

Cindy: I wanna grow stronger.

Diane: Stronger…stronger… This guilt is yours.

Cindy: It's yours and I won't carry it anymore. I'm putting it down now.

Cindy begins to cry softly and rock back and forth. I sing "hmmmm" and return to A minor 7 and D minor 7 chords. I am playing slower and softer now. I sing in a lullaby-like fashion. I am also taking deep breaths to

resource myself, as this was a very emotional process for me as well. Cindy begins to sing softly after several minutes.

Cindy: What a cleansing need, healing that part of my body.

Diane: My body.

Cindy: So my water can run free—healing clear water.

Diane: Healing, clear water.

Cindy: It flows and then comes back to my heart.

Diane: Comes back to my heart.

Cindy: And then flows out again.

Then we both continue singing on "m-m-m" for several more minutes. This is an important time, a time for Cindy to take in what just occurred and to come to closure with it, at least for this session.

Conclusion

Working through unresolved trauma is a long and difficult process that requires courage on the part of the client and the therapist. There is no quick fix. Cindy was not cured after this critical session, but she experienced some relief and took another step in healing the sense of shame she had carried with her for years.

We would return to memories and feelings surrounding the sexual abuse for the next eight years. Each time Cindy was able to feel her anger toward her uncle and her parents and express it, something shifted psychically and she felt more empowered. Instead of judging and attacking herself, she began to use her aggression to set boundaries, protect herself and use her energy to further her creativity.

As Cindy continued to process through the music and words, she was able to grieve for the childhood she never had and the little girl who still lived inside of her. Together we mothered this child, and as her unmet needs were acknowledged and met, Cindy's inner child began to heal and become more integrated into Cindy's sense of self. As Cindy grew to trust that I would not abandon her, that I truly accepted her real self with all its imperfections, she began to accept herself and the reality that her parents were wounded people who would probably never change, but that she could and would continue to heal and have access to more of herself.

Singing can enable clients to reconnect with their essential nature by providing them with access to and an outlet for intense affects. Singing

offers a way for the disembodied spirit to incarnate because painful feelings can be put into an aesthetically pleasing form. Images that are frightening or ugly become easier to relate to when they are played, sung, or expressed in a creative medium. Cindy expressed it this way: "When I sang just now, I took something ugly that happened to me and made it beautiful."

Deep characterological change requires a controlled regression within a safe and caring therapeutic relationship. Then clients can remember, fully experience, and make sense of the feelings, images, and sensations that overwhelmed them as a child, intolerable because of the loneliness, because no one was present to help the child contain, understand, and digest the intense affects they experienced.

Vocal psychotherapy provides clients with the opportunity for a reparative relationship within which they can experience a therapeutic regression. They can return to the "scene of the crime" companioned by an empathically attuned other. Traumatized clients can then grieve what was and what never will be, make meaning out of false beliefs and old confusions, and accept and integrate the past so that they can live more fully in the present.

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Chapter 8

Sandplay Therapy with a Traumatized Boy

Lois Carey

Sandplay therapy is a method that is quite beneficial for any child or adult who has been traumatized. In and of itself, sand has healing qualities and has been used for centuries in healing rituals by Navajo Indians and other groups. Sand is of the earth and, as such, reconnects and grounds the individual in a way that is not possible with other media. Think of your own childhood, the many hours spent digging at the beach and constructing sand castles, forts, roads, etc. You made your own story in this way and usually felt calmed and satisfied by the experience. The focused intensity of that kind of experience is similar to what contributes to the healing effects of sandplay therapy.

The two main pioneers of sandplay therapy were Margaret Lowenfeld (1979) in London, and one of her gifted trainees, Dora Kalff (1980). Dr. Lowenfeld had sand and water available in her consulting office and credited the children with inventing what she termed the "world technique." The children took miniatures that were available, and constructed scenes in the sand with them. Dr. Lowenfeld understood that the children, through their play, were showing her their psychological issues. Some years later, Dora Kalff, at Carl and Emma Jung's urging, went from Zurich to London and studied with Dr. Lowenfeld. Kalff was in training to become a Jungian analyst at that time and was especially gifted with her child patients. She returned to Zurich and added her interest in Zen Buddhism to her Jungian knowledge of symbols and archetypes. Kalff called her method "sandplay." She believed that the essence of sandplay was nonverbal and symbolic, and that when objects were placed in the sand they were able to contact each person's unconscious process. It was her belief that, over time, the process

revealed what was needed for deep healing to occur, and that the therapist's intuitive understanding of what was illustrated was the necessary ingredient to process the experience and did not always have to be verbalized.

The sandplay literature describes the equipment used (see Appendix 8.1), the types of cases treated, and the positive effects of sandplay when used therapeutically with both children and adults (see References). Included below are some general guidelines for the use of sand in therapy, with an emphasis on trauma.

The process of sandplay therapy when trauma is the issue

The first session

After a thorough history has been taken with the child and his family, they are shown the playroom, which is outfitted with two sandboxes (wet and dry) and a large collection of miniatures (suggested categories are given in Appendix 8.1). The child is told that he is free to use one or both boxes of sand to construct a scene, using miniatures that are available. It is explained that at the end of the session, time will be allotted in order to discuss what has been observed or to tell a story about what the entire scene might represent. The client then chooses between the wet sand and the dry. There is no limit set on the number of items chosen, but on the first session I usually do not state that, as I prefer letting the client begin to set his own limits. My instructions are that they can use whatever toys they would like to construct a scene, and that they will know when the scene feels complete. My role during the initial session is primarily that of observer (as well as timekeeper).

It is important to note that different ages use the sandtray in various ways. For example, adults will make a scene and leave it intact, whereas children will make a scene and then usually will act it out.

I take note of the process as it evolves, with particular attention to the following:

1. Which box is chosen—wet or dry? This can be diagnostically relevant because certain categories of clients refuse the wet sand (obsessive compulsive, sexually abused, schizophrenic, to name a few). Some clients may refuse to use sand altogether, in which case it is never forced. The resistance is there for a reason and must be respected.
2. How does the child or adult begin? Enthusiastically, tentatively, fearfully?

3. How does the client select the miniatures? Thoughtfully, indiscriminately, by emptying an entire shelf (common with children under four)?
4. Are any miniatures selected and then not used? Why not?
5. What is the client's affect as the scene develops? Calm, agitated, thoughtful, intense?
6. How much time does it take to construct the scene? Is it completed quickly or is it a prolonged process?
7. What is the client's affect when the scene is completed?
8. Does a story come readily, or is there hesitation?
9. What kind of therapist input is needed? Questioning should be minimal and must *always stay in the metaphor of the items used.*

Subsequent sessions

If this is a non-communicative client, or an overly verbal one, the therapist can be somewhat more directive. For example, with the non-communicative client the therapist might engage in a mutual storytelling technique when the scene is completed. With the overly verbal client (especially an adult), the therapist can instruct her to "feel" her way into the sand without talking. If the client had previously used the dry tray, she might continue to do so, or else it can be suggested that she try the other one in subsequent sessions.

Post-scene discussion

The post-scene discussion is incorporated into each therapy session. This is the culminating point of each session, when the dynamics that have been observed during the process can be verbally elicited. The child (or adult) is given the opportunity to tell a story about what has been constructed, but all discussions should be kept within the metaphor of the tray. This is the portion of the session where the therapist's intuition and empathy allows her to begin to summarize what has been observed and to put it all into perspective. The therapist's input is not always verbal, however, but an understanding of the message that has been conveyed is vital. It is not an easy task to show understanding without verbalizing, but it becomes easier as one gains more experience with the technique.

One of the important facets of all sandplay therapy is that the therapist might elect (in subsequent sessions) to suggest that particular issues be addressed. This is an example of the fact that sandplay therapy has no set

rules, but can be adapted to the needs of the client and/or the situation. Concrete direction can be an essential element in trauma work, where one is often more directive than in child-centered sandplay therapy.

Termination

One never knows at the beginning of treatment with a traumatized client how long the process will continue. That is strictly case-specific. However, when the therapist can intuit that the presenting issues have been addressed, he might move towards verbalizing the experience and, once that has been accomplished, discuss termination with the client. This is a very delicate part of the process and one that requires sensitivity and insight from the therapist so as not to retraumatize the individual by a premature termination. If one is attuned to the pace of the client, this stage is usually accomplished satisfactorily. Generally speaking, I believe that termination needs to be done slowly and carefully over a period of one to two months, in order to ensure that the trauma issues have been fully dealt with and that the client can then move on.

Case example

This case is that of a 12-year-old boy, whom I will call BD, who lived with his natural mother and his stepfather. He was in the sixth grade in school and a very high scholastic achiever. The reason for the referral was that he had been drawing sexually explicit pictures in school of oral and anal sex. The school called his mother to advise her of this. Further history revealed that BD had been sexually abused by an uncle (mother's brother), from the age of four to eight. This had been revealed about two years earlier when a four-year-old cousin told his mother that BD was touching his genitals. BD's family had had some brief therapy at the time when the abuse was revealed, and the uncle had apologized to the child for the abuse. He (the uncle) was 14 or 15 years old at the time of the abuse and had spent one or two nights in jail after it became known.

Part of the abuse was related to an incident when BD had caught his uncle cross-dressing. His uncle threatened BD's life and the life of his parents should he tell. It appeared to be that incident that led the uncle to seduce the child. While the abuse was going on, the child was having nightmares related to chopping up women, and he showed quite an interest in knives and swords at that time. In addition to the sexual abuse, the uncle also forced BD to undress, and took pictures of him. Supposedly, those pictures were destroyed.

BD's parents were divorced when he was about 18 months old. There was no contact with his natural father. However, his mother believed that his father and the uncle/perpetrator had also been involved in homosexual sex.

The family of BD's mother was rife with alcoholism and incest that went back at least three generations. Her new husband (the marriage had lasted four years at the time I treated the child), turned out to be a sexual predator who cruised local bars at night in attempts to pick up young males. This was later learned through the referring colleague who treated the mother, the uncle, and several of the aunts.

The stepfather was over-involved with BD's treatment process, which I understood when his problem behavior was disclosed. On the first interview with BD's parents, the stepfather said that he wanted to take the child to a urologist to check out the size of his penis and that he wanted my opinion on that. He felt that the child's penis was extremely small. I told him that I thought taking him to a urologist was unnecessary and would only put further focus on his problems. Later, due to the stepfather's intrusion into the process, the child's treatment ended abruptly—about six months along and just at the point when it seemed that BD was about to talk to me. Our communication throughout most of the sessions entailed my commenting on how BD might be feeling, followed by a nod of acquiescence or a shake of his head that I had got it wrong. This was undoubtedly the most nonverbal case I have ever seen, but his sand scenes will illustrate some parts of the process. I am including descriptions of other sand scenes (not illustrated) as well.

BD's first sand scene consisted of knights riding on horseback, who were charging a dinosaur. There is also a half-buried snake, and two wizards that are also half-buried. I have found it to be almost a rule that in sexual abuse cases, you will see figures half-buried—and almost always in dry sand. It appears that the wet sand is too uncomfortable at this early stage for the child to use. BD produced two scenes while I was getting history from the parents in an adjoining room. In the second sand scene, BD showed a Tyrannosaurus Rex devouring an alligator. One could surmise that it was an expression of his rage at his situation.

The next sand scene (Figure 8.1) shows another major battle being set up. This time a work truck has been added. That might symbolize that we are about to dig into the problems in this case, and that there is mechanized energy available to do so. BD very carefully covered much of the scene with sand (as you can see in Figure 8.2). This type of half-covering of things is something he did often with his scenes.

Figure 8.1 BD's battle scene with work truck

Figure 8.2 End of battle scene

The following week another battle was illustrated, this time with soldiers. So, you can see that the transition from BD's use of very aggressive animals to soldiers was made relatively quickly. This is considered a move towards more human representation. Once again, he carefully covered most of the figures.

During another session, the child found matches and candles that were part of the equipment in the room. Lighting the candles and burning them became an integral part of several sessions. He also burned the genitals of the dinosaurs and the soldiers. The black smoke that filled the room from the burning plastic was too much for both of us, however, and I had to limit the burning somewhat—so I brought in popsicle sticks that he could burn instead, if he felt he needed to. I have been questioned numerous times about this; I felt that this boy's wounding was so deep that it was important for him to burn the hurt away symbolically.

The next scene was yet another battle where he buried many of the soldiers in the sand.

After a lengthy summer vacation break, BD produced a scene that was similar to what he had made on his first and second sessions. It was as

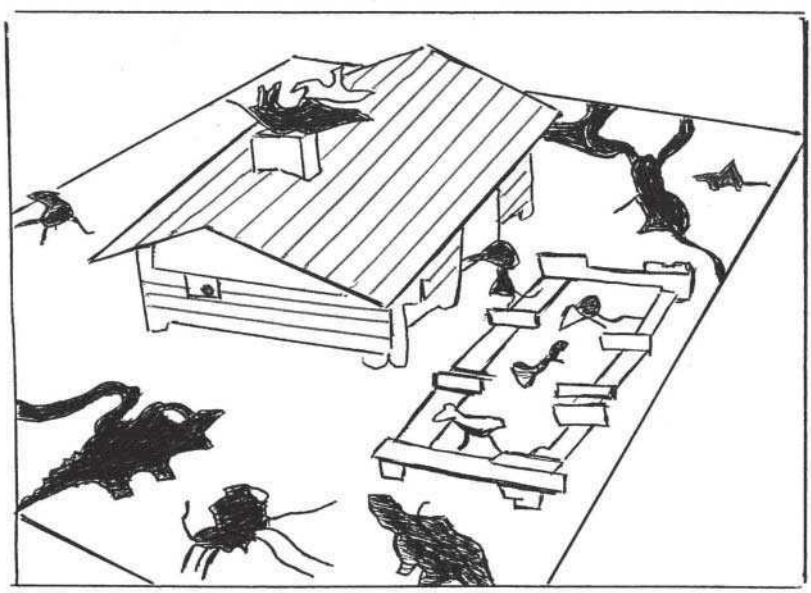

Figure 8.3 "Something evil in the house" (drawing from original photograph)

if he had to go back and redo some of the earlier stages. Then he produced Figure 8.3 which I later understood was an attempt to disclose that there was something evil in his house. Figures 8.3 and 8.4 did not photograph well so they are reproduced in drawings rendered by Suellen Lash.

He first made a house out of Lincoln Logs (a kit from which children can build a log cabin or other structure), with a fenced-in area in the front yard. He then surrounded the house with dinosaurs, snakes, and large ants. This was one of the most troubling scenes that I witnessed, and one that communicated his pain in a way that words could never have expressed. At the time this scene was made, the information about his stepfather's activities had not yet been revealed. BD was trying his best, without words, to let me know that he could not talk about the depth of his despair. My attempts to encourage him to verbalize his concerns about "what was going on in the house" were met with his usual stony silence. Shortly after this scene, I had a parent conference and tried to probe into what might be occurring. I now believe that this is what pushed the stepfather to want the boy to terminate therapy with me.

Following this, BD used soldiers, a dinosaur, and a mummy in a scene. The hopeful sign to me was a wishing-well that he had perched on the edge of the box. This might have signified his hope that some of his wishes would be granted. In addition, he placed the wounded soldier on a gurney, being helped. The hurt soldier often signifies that the child is aware that therapy is a place for wounds to be healed. In the upper right corner of the scene, a bunny hutch was used as a jail. I asked if that was supposed to be the jail that he wished his uncle to be in. He nodded his assent.

In his next sand scene, he constructed two jails and was able to verbalize, on his own, that this was where his uncle belonged (also his stepfather?). On another level, however, this might also have signified just how bound up he felt, or that he had managed to split, or dissociate.

The soldier that is seen in the popsicle stick enclosure (Figure 8.4) was a toy that had been burned previously and was, I discovered through my questions, another image of his uncle. This can be interpreted as an attempt to illustrate how he would like to punish the offender(s), and an attempt to symbolically eradicate his own wounds.

The use of fire can be viewed in several ways. It has many aspects, both positive and negative. Its place in the alchemical process is certainly unquestionable, as the early alchemists attempted to change base metals to gold by the use of fire. The sandbox is often viewed as an alchemical

vessel, the place where change can occur; therefore BD's use of fire could be interpreted as curative, at the same time as serving to illustrate his trauma, which appeared to be a definite possibility in this case.

During the next session a battle resumed with soldiers, many of whom again were buried in the sand.

One day I suggested to BD that perhaps he might want to draw a picture instead of using sand, and I took out all the art materials. He said he wanted to use all of them, which he methodically did, one stroke at a time and using one type of color at a time—tempera, colored pencils, markers. When he finished, I asked him what it looked like to him. "A waterfall," was his response. To me, it certainly looked as if the picture represented all the fire that he had been involved with for the past couple of months.

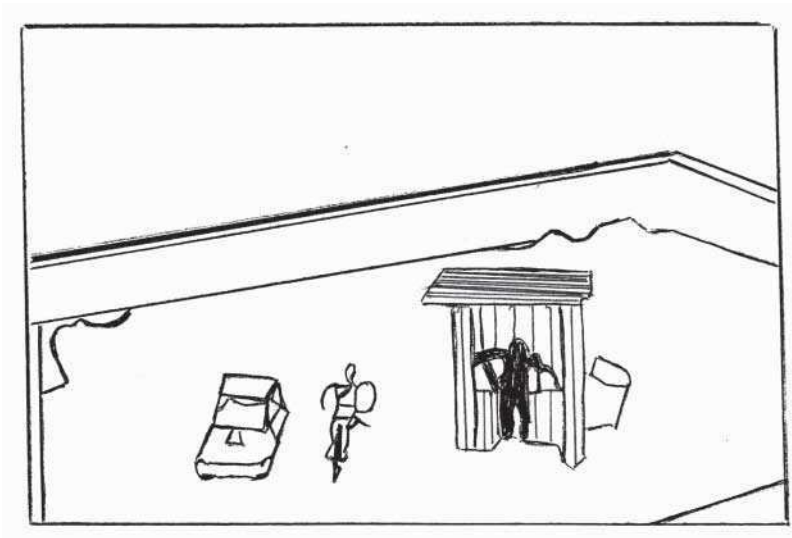

Figure 8.4 Soldier in jail (drawing from original photograph)

Several weeks after BD made this drawing, his stepfather decided that he should terminate with me. He wanted to take BD to a "more directive, confrontive" therapist. So we had a premature termination. I was not at all happy with this parental decision, but these are some of the troublesome issues that therapists who work with children have to contend with. All of my attempts to reverse this decision were rebuffed.

I did, however, get some feedback from the colleague of mine who had referred the child to me. BD, his mother and stepfather moved to the south about a year or so after I had treated him. The mother apparently knew of her husband's addiction to young boys, but decided to stay with him nonetheless. I have no idea if they received counseling or if the stepfather had any kind of treatment. BD was then about 17 and doing extremely well in high school. He had a girlfriend, and seemed quite happy and well adjusted. The parents never took him to another therapist, so I can only surmise that through the experience with sandplay he had been able to discharge enough of the rage from his abuse to carry on with his life. I am of the opinion, however, that he may be plagued again with the remnants of his very serious abuse. It may be hoped that the positive experience he had with sandplay will help him seek appropriate help when that time comes.

Sandplay, with its nonverbal component, was the catalyst that enabled this almost mute child to express the inexpressible in ways that words could not have done. The verbal input in this case was primarily mine as I attempted to verbalize his experience for him.

Appendix 8.1: Materials

Two sandboxes, each one 19½" (46cm) x 28½" (70cm) x 4" (10cm), with the bottoms painted blue; one box contains damp sand and one contains dry.

Miniatures of various types; the suggestions in the following categories can be added to or subtracted from, depending on each therapist's choice:

1. *Animals*: wild, domestic, prehistoric, sea creatures, birds, fish, butterflies
2. *Living people*: men, women, children; varied races; varied occupations; cowboys; cowboys and Indians
3. *Fantasy figures*: superheroes, Disney, fairies, mermaids, gnomes
4. *Transportation*: land, sea and air items; cars, trucks; fire trucks; police cars; ambulance; tanks; boats; ships; planes, helicopters, military
5. *Scenery*: buildings (all types), vegetation (trees, flowers), bridges, fences
6. *Equipment*: implements to make roads, farms, signs, fences, child's playground; hospital beds; doctor kits
7. *Miscellaneous*: wishing-well, coffin, rocks, shells, beads, etc.

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Chapter 9

Sandplay Therapy and the Body in Trauma Recovery

Dennis McCarthy

This chapter describes an approach to play therapy that is body-centered, with sandplay as its centerpiece. It examines in particular the effects of trauma and the efforts to heal from it in the context of children's physical experience of themselves, via the therapy process. Trauma is, after all, first and foremost a physical phenomenon. Whether the trauma is the result of physical or sexual abuse, medical interventions, or neglect, it is the body that experiences the trauma. The psychological effects and defensive reactions which arise are a result of this.

Concepts such as "container," "filter," "energy," "discharge," and "pulsation" will be explored. The theoretical basis of these pages is a combination of the work of Wilhelm Reich (1942, 1945), Alexander Lowen (1970, 1990), Carl Jung, and Erik Erikson (1977), among others, but is largely the result of 30 years of children teaching me about their experience of being children.

My work as a therapist initially evolved out of my experiences as a dancer. I studied and performed a wide variety of dance forms from all over the world. In all dance forms, movement is the language of communication and the body is the vessel of expression. A victim of trauma myself as a child, I found in dance a means of slowly reclaiming my body, separating the positive sensations of moving freely in the dance from the embedded negative memories of abuse and neglect. This was a very long process that continues to this day, but from the moment I began to have a positive physical experience via movement, something fundamental shifted: the possibility of pleasure was reintroduced.

As I began to study psychotherapy and to work with children, I was aware that for them the body and its impulses and movements are still their

primary language. Play is a totally physical experience for children. It is easier for them to discharge the negative feelings in their bodies and psyches and reinstate pleasure via play. I developed a method that uses this body-centeredness as its core, even as I included blocks, art materials, storytelling, and especially sandplay as tools.

I discovered the work of Wilhelm Reich early in my studies. He was a psychiatrist and student of Freud's who forged his own (to western thinking) unique form of therapy, which was energy-focused. Reich was the first western psychological theorist to my knowledge who talked about energy, let alone based his entire work on it. Now it is a normal part of our vocabulary, being used in a psychological context as well as in everyday language. Wilhelm Reich's theories on energy formed the basis of bioenergetic analysis and many other body–mind techniques currently in use.

The word "energy" is synonymous with aliveness and vitality. If we think of energy as the manifestation of one's aliveness, then the movement of it through the organism, the amount and availability of it to the individual, is essential. This energy governs the entire organism; it is expressed in the emotions as well as the purely biophysical movements of the organs (Reich 1945).

Reich saw this energy as "pulsatory," an expansion and contraction, as evident in respiration. A simple experiment with an amoeba demonstrates pulsation and its essentialness to life, observable through a microscope. Energy builds up in the amoeba, creating a "charged" state. This energy is discharged and the amoeba relaxes. The cycle begins again, the amoeba is never still. Normal expansion is exaggerated when the amoeba reaches out for food. The reverse action, or contraction, occurs when the amoeba is attacked by the environment. If it is attacked repeatedly, the amoeba expands more cautiously, more anxiously. If the attack continues, the amoeba stays contracted, in a state of defense. If the attack persists beyond this point, the amoeba will lose energy, shrivel up and die (Baker 1967).

We can begin to see the basis of emotional health and emotional disorders via this simple yet profound experiment. We can also begin to think of the effects of trauma on the organism on this fundamental energetic level. Because expansion is synonymous with pleasure and contraction with anxiety, we can begin to see the effects on the growing child of a negative growth environment or any internal or external trauma, at the most basic level of existence.

The movements of the amoeba in its free-flow state actually look much like the natural movements of an infant. We can observe the infant reaching out with eyes, mouth, and hands for contact and food. We can observe it contracting in response to a sharp sound or an unpleasant sensation, such as hunger or a wet diaper.

The ability to expand and contract is synonymous with life. If the biological oscillation is disturbed in one direction or the other, i.e. the function of expansion or contraction predominates, it signifies that there must be a disturbance of the general biological balance (Reich 1945).

At times, it is inevitable that life will cause us to contract, and that is a necessary part of the cycle. When contraction dominates and upsets the balance, we have the natural capacity to emote, which reinstates the natural flow of aliveness. Literally defined, the word "emotion" means "moving outward or pushing out." We must take the word literally in order to understand how it relates to maintaining or reinstating health.

Dr. Alexander Lowen, a psychiatrist and student of Reich's and a pioneer in his own right, developed a system of working energetically with patients which he called "bioenergetic analysis". "Bioenergy" refers to the life energy which provides us with the ability to function. Lowen envisions the basic human structure as a pyramid which he calls "the hierarchy of the personality." On the deepest level are the energetic processes that activate the person. These processes result in movements (reaching out for love, as an example) which lead to feelings and end up as thoughts. The ego is at the pinnacle of this pyramid, arising out of all that is below it (Lowen 1990).

Pulsation is the basis of respiration, peristalsis, the beating of the heart and other bodily functions. Because all life pulsates, from the simplest, single-celled organism to the oceans with their tidal motions, pulsation is what links us to the rest of life and to the cosmos. Pulsation is present and often visible when therapy is "charged" or alive. I have frequently noticed this process of pulsation in sandplay and other play configurations with children when they are truly engaged in the experience. It can be seen in their drawings, their block formations, and their spontaneous play. Their play opens up and expands in sandplay, filling the box. It often spills out of the box into the room and then, over the course of several sessions, it begins to recoil. Sometimes this expansion and contraction happens from week to week. I have observed it many times in slides of sand scenes taken by other therapists whom I supervise, who have no awareness of this phenomenon. In other words, this expansion and contraction happens and is often visible

when there is growth occurring, regardless of whether the therapist sees it or not. The dreams of the adults I work with in analysis often reveal a similar thing. The cases that I will be citing will demonstrate this process in children's play.

Play is always primarily a physical experience for the child. If we pay attention to the physical movements and notice the ways in which they affect the child, we observe that this tendency (of expansion and contraction) seems to intensify. When the child squats by the sandbox and begins to manipulate the sand, especially when she is truly engaged, she often begins to breathe deeper, drool, pass gas, flush, and sometimes even break out in a sweat. The child often needs to rush to the bathroom. The "energetic processes" which Lowen refers to are being affected and, as this is the deepest level on which we live, there is more potential for deep change when this happens.

Lowen speaks at length in his writings about the need for each of us to develop a psychophysical filter, which can help us to regulate energy and protect us from all that is threatening to us, and so helps us to know who we are. This filter arises out of the capacity to say "no." The "no" functions as a psychological membrane that parallels in many ways the function of a physiological membrane. It prevents the individual from being overwhelmed by outside pressures. It guards against an exaggerated impulsive reaction for a person, who can say "no" to others and can also say "no" to his own desires. It defines the ego boundaries of an individual, just as the physical membrane defines the body's boundaries (Lowen 1970).

This idea of a filter being created by the capacity to say "no" is of the utmost importance when working with trauma survivors. This ability to self-assert and the sense of self-awareness which arises from it, has either been violated or destroyed in cases of trauma. Once this filter is created or reinstated, so is the capacity for psychological health. Knowledge is a function of discrimination. To know what A is, it must be distinguished from all that is not A. Knowledge arises from the recognition of differences. The first difference that an organism can recognize is between what feels good to the body, or pleasurable, and what feels painful (Lowen 1970).

My means of helping children to build or rebuild this filter involves my encouraging their self-assertion via the use of negative discharge and opposition. They begin to sort out what is "not them" from what "is". Sand is a powerful tool in this filter-building process. As a material, sand is a perfect filter. Things may disappear into it, be absorbed by it, emerge from it. It may

be made very firm by the addition of water, or left very porous and dry. As the child manipulates the sand he is manipulating himself. This method also offers a very safe setting in which the lack of filter can be expressed and then resolved, slowly but surely. The sandbox is also a perfect arena for the oppositional play so essential to the process of growth. The following case is a perfect example of the intense physical connection and subsequent release in a child's experience of sandplay and its effectiveness in trauma recovery.

Case example

Five-year-old Josh began therapy after years of medical trauma. A serious, potentially fatal illness sent him to emergency rooms many times, where he was subjected to repeated blood tests and transfusions. These were often administered with great insensitivity. Josh's parents were loving and devoted to him, and seeing their son ravaged by illness had left them feeling devastated. This illness was something they could not protect him from. They lived in constant fear of him becoming sick and starting the cycle of medical intervention all over again. There was an operation which would most likely cure the illness, but Josh had to be in optimal health for his doctors to perform it. They recommended play therapy in the hope that it would strengthen his immune system.

Fear, combined with frequent bouts of illness, had frozen Josh energetically. Periodic fits of rage would temporarily release this frozen state, but these rages were becoming problematic. Josh had been unwilling to toilet train and, prior to therapy, had become unwilling to defecate at all. Josh's physical and emotional experiences had been straight out of Reich's simple amoeba experiment. His body had been under attack from within and without, and he was contracting more and more, at the expense of his much-needed life force.

Josh entered the play therapy space in his first visit wide-eyed with terror. I am sure he suspected yet another assault of some sort on his body. Josh's body had a small, frail, anemic quality. He shook my hand very formally when we met and his hand had a cold, energy-less feel to it. His head was disproportionately large for his body. He had been told that I had a sandbox in my office, and underneath the fear I could sense a curiosity and an eagerness to play. (The act of playing, which is such a symbol of a child's aliveness, often has this immediate power to overshadow his fears.)

Josh readily approached the sandbox, crouched by it and began to play. At my suggestion that he make a scene in it; he slowly placed several

houses, trees, and people in a small, tight cluster. He then told me that beneath the sand a fire was raging and that it was about to erupt. He was checking with me to see if it was okay. We waited together, he with great concentration of energy. Then suddenly, he reached into the sand and began to blast huge amounts of it into the air, covering everything. He repeated these eruptions again and again and began to pass large amounts of gas with his body as well. He continued this for the entire visit, both the sand and his body erupting with the pent-up tensions therein.

When his parents returned to fetch him, Josh was clearly in a very different energetic and emotional state. His parents were cautiously amazed. That week he began to use the toilet and in a few weeks it was a normal part of his life.

Although Josh's emotional condition had a physical basis, his emotional response further affected his physiology, in an ever deepening contraction. When metabolism is reduced as in illness, motility is decreased. Any decrease in the body's motility affects its metabolism. Josh's fear kept him in a "held-in" breathing state, except for his occasional outbursts of rage, which had such a negative effect that they encouraged rather than relieved the contraction. The intimate connection between breathing, moving, and feeling is known to the child but is generally ignored by the adult. Children learn that holding the breath cuts off unpleasant sensations and feelings. They suck in their bellies and immobilize their diaphragms to reduce anxiety. They lie still to avoid feeling afraid. They deaden their bodies in order to not feel pain (Lowen 1970).

The childhoods of both of Josh's parents had been very traumatic. Both had been sexually molested during adolescence. Both had kept it a secret. Once this information came to light, and while working with them, I encouraged them to relax and let go in order to help their child grow. This information explained the severity of their reaction to their son's trauma. Their over-protectiveness was influenced in part by their own deep-seated traumas. Josh felt this and was further contracted by it. His first scene of the tight little village was certainly how his family unit must have felt. By blasting it to bits, he began a process of helping not only himself but his parents as well.

Josh's use of the sandplay had a very immediate effect on his physiology and affected his ability to fight off illness. From the day I began seeing him, he had no more visits to emergency rooms and no more need for transfusions. His immune system had got strong very quickly and

within several months he was able to have the necessary operation, by which he was cured of his illness.

All of Josh's sessions initially took place in the sandbox. He literally did not notice the rest of the room; it didn't exist for him. After his initial "erupting" scenes, all of Josh's play involved bulls as the main characters. The bull became his totem. I have numerous bulls in my collection of miniatures and Josh used them all, usually as a group of comrades fighting a variety of foes that were always invisible. As Josh's illness was invisible, this was not surprising.

These battles grew in intensity and loudness. Josh's voice was barely a whisper at the onset of treatment. Now it increased to a roar. I was both a witness during these bull battles and his assistant, an integral part of the process, yet peripheral at the same time. Josh grew by leaps and bounds during this period, which further encouraged his parents to let go.

Eventually the action of his scenes began to spill out of the box into the rest of the room. The battles had become so intense that they needed more space. As Josh's energy and body expanded, his play did so as well. He became much bigger, both in body and in spirit. The battles became so intense that they required more space. He used the floor and various pieces of furniture throughout the room. This expanded play paralleled and precipitated a period of physical and social expansion in his life. He began to try new things at home, such as eating different foods, making many new friends and sleeping over at their houses, and sleeping alone in his bed.

The bull was the constant heroic symbol in all of Josh's play throughout this period. In his latter sessions, Josh created a scene which was again limited to the box and strikingly different in scope. A new human hero appeared. This hero would ritualistically eat one of his pet bulls before going into battle, thereby "having the power of the bull inside of him," as Josh informed me. This brought to my mind the use of the sacrificial bull in ancient and even contemporary religious rites. This primitive communion rite made sense as a resolution of the problem for Josh. His body now reflected the strength and aliveness of his favorite symbol.

Josh's initial play brought about a rapid release of the pent-up tensions at the root of his compromised immune system. He made a big leap towards health in that first session. Then there was a gradual expansion, bringing with it increasing health and a reinstatement of normal developmental growth. His last scenes were a contraction, but

this time a healthy contraction, a pulling into the self to more fully experience the self.

Physical, psychological, and sexual abuse present a more tenacious problem. As with medical trauma, the body, as the child's primary means of self-experience and self-expression, has been assaulted. Unlike medical trauma, the abused child does not have a parent hovering nearby attempting to comfort him. Rather, the abuse happens in secret or is often actually perpetrated by the parent or someone in the family system. It is sometimes done ostensibly "for the child's own good." There is always a feeling of betrayal, even when the parents are unaware of the abuse. The parents are still godlike to the young child in their powers and he feels that they "should be aware." A body-based play therapy approach is a very powerful and effective one because it allows for the catharsis that is so necessary for the abused child to recover.

The brilliant child psychologist and theorist Erik Erikson (1977) posited three types of play: traumatic, cathartic and integrative. If we acknowledge in certain play configurations that we are working through some traumatic experience, we also note that the very factor of playfulness transforms them into acts of renewal. If some such events seem to be governed by the need to communicate, or even to confess to something, the element of playfulness adds the joy of self-expression. And if the play so obviously helps the exercise of growing faculties, it does so with inventiveness and abandon.

Cathartic play allows the body to rid itself and the psyche of the destructive sensations and experiences of abuse which otherwise become deep-rooted, chronic problems. Although this sounds simplistic, it is borne out by my many years of experience encouraging cathartic play with children. With all deep therapeutic work, the process of breaking down unhealthy psychic structures and supporting the growth of new, more functional ones is what occurs in healing.

Cathartic play always involves the breaking apart of form in the service of a new form. In Josh's example, his erupting allowed his body and its defense system to reorganize. When one experiences this catharsis at first hand, it is as exhilarating for the witnessing therapist as it is for the child.

Case example

Seven-year-old Mary began therapy with a long list of seemingly disparate symptoms. On the one hand, she was extremely oppositional, and had been so for many years. She threw frequent tantrums, hitting and kicking her mother in particular. On the other hand, she would cling to her parents in the presence of others. In social situations outside of her home this tendency intensified. She had poor self-esteem and no tolerance for frustration.

Mary's parents ran a large horse farm and were busy from morning until night. From the age of one until six, Mary had been cared for by a babysitter who Mary's mother described as "very harsh but a good housekeeper." The babysitter had finally been replaced after an incident in which she brought Mary to school and then attacked her in the presence of her teachers. The teachers said the woman had seemed possessed, screaming obscenities and oblivious to their presence. When the school notified Mary's mother, she fired the babysitter on the spot, but had often wondered if the years spent in her care had anything to do with Mary's behavior. This mother was filled with fear and guilt. Mary's mother, herself, had been raised by a very cruel father who had beaten her into submission. Ultimately she accepted his way as right, but kept a connection to her true self through her love of and relationship with horses.

When I first met with Mary she struck me as a chronically tense child. Her neck was bowed and her mouth was taut, making her speech inarticulate. Her initial sand scene showed a deep ravine spanned by a bridge. On one side, a tribe of Indians lived in peace. On the other side, an army was preparing to attack them. A monster stood in the middle of the bridge. The monster had to be reckoned with by whoever crossed the bridge. As Mary made her scene, she began to tell me about recurrent nightmares she had involving bridges: she and her family would be attempting to cross them and they would collapse or fall apart. At my suggestion, Mary began to talk about her former babysitter. "She was nice on Tuesdays, and sometimes on Wednesdays," she said. When I asked her about the other days, Mary admitted that they had been very bad. The woman had been verbally and physically abusive and in strange and sadistic ways. I suggested we make this babysitter out of clay and smash her. Mary jumped at the chance and put an enormous amount of energy into the assault.

Mary left that first session feeling very pleased. At home she seemed happier than her mother ever remembered seeing her. However, by the end of the evening she had dissolved into tears. This was not a usual expression of emotion for her. When I saw Mary next, she told me that the bad dreams had become much worse. She made an identical scene to her first one and again spent time smashing figures, but this time designated them as her mother. She also began to tell me more about her babysitter's abuses, including having her mouth washed out with soap daily. No wonder her mouth was so taut! She explored more ways of venting her rage, and decided that leaping from a chair onto the floor with a loud crash felt best.

Mary's sand scene had changed by our next meeting. The bridge was gone and the ravine had begun to dissolve. It was now a valley, with wild horses living there in natural paddocks. Wildcats lived in small caves on the hillside in "peace and harmony" with each other. In this meeting, Mary's anger was focused solely on her parents who had left her in the care of the cruel babysitter. Mary's mother needed a lot of support from me in tolerating and understanding her daughter's rage, as it began to be more intense and directed at her at home. She came to realize that her own parents' strictness had been wrong and had taken a horrible toll on her. With this mother's knowledge of how her own history had impacted on her child, the dynamics changed and she and Mary developed a stronger bond of love and trust. Mary began sharing with her mother, especially at bedtime, more horror stories of abuse at the hands of the babysitter.

Mary's next sand scene revealed that the ravine was gone and was replaced by a round island encircled by a river. In each corner of the box, wildcats and Indians lived in peace. Horses lived on the island in nest-like paddocks. The island and the river were cut off from each other by a wall at first. Mary then decided to let the river flow in so the horses could drink, and she made a small opening in the wall. This opening felt significant. I could sense a shift in Mary's physicality. Something was now open in the stasis in which Mary's growing self had been stuck. She spent the rest of her session leaping from a chair onto the ground and stomping her feet with gusto. This leaping was now feeling like real play.

Erik Erikson (1977) cites Plato in his *Laws* as giving the best formulation of play. He sees the model of true playfulness to be the need in all young creatures, human and animal, to leap. To truly leap, one must learn how to use the ground as a springboard and how to land resiliently and safely. It means

to test the leeway allowed by given limits, to outdo and yet not escape the laws of gravity. Thus, wherever playfulness prevails, there is always an element of surprise that surpasses mere repetition and habituation. At its best, it suggests some virgin chance that has been conquered, some divine leeway that has been shared. When this "happens," it is easily perceived and acknowledged (Erikson 1977).

Case example: Mary, continued

Several more visits occurred where Mary continued to leap and also to explore other play possibilities. Then she made the following scene in the sand. A huge mountain loomed in the center of the box. A vampire lived in a graveyard on top of the mountain. In a cave further down the mountain, a monster guarded a treasure it had stolen. In the surrounding valley, there was a village and a group of wild horses. The villagers had to get the treasure back because the horses needed it to survive. Mary sat silently for a while in front of her scene before she brought it to life. The villagers stormed the mountain cave. Mary reached her hand into the cave and demonstrated the battle that was taking place inside with much shouting and flinging of sand. The whole mountain shook. When it was over, the villagers had changed the monster into something good. The vampire was gone. Mary looked shaken but satisfied.

Mary's life began to blossom after this scene. The bad dreams stopped. Her relationship with her mother had become very positive. For the next several visits, Mary made lovely, pastoral scenes reflecting her new-found strength and health. Her final scene was really a creation or re-creation myth. She ceremoniously placed four large crystals in a circle in the center of the box and then inscribed four arcs in the sand around this circle. She placed groups of animals in each arc. Then she began to relate, in an emotionally charged voice, a story about a quest which each group of animals had undertaken. Each group had traveled through "an endless cave" and battled a two-headed dragon. Each had brought back a treasure. One group had brought back a magic violin, the first violin. Another group had brought back a magic tree—again, the first tree. Mary told each story with deliberation. She herself was surprised and moved by the stories. When she left that day, I became aware how much her body had changed in recent weeks. Her back was straight, her mouth was relaxed, and her eyes sparkled.

Ferenczi (1933) noted, in the early days of psychoanalysis, that healing occurred when abused children were able to translate their traumatic experiences into a private language of their own. Sandplay is the ideal format for this private language to be developed and spoken. The pictorial images satisfy the child on both a psychic and physical level in a way that nothing else seems to do. It is not important that I fully understand what is being said, although I did with this child. It is enough to allow the process, to facilitate its formation.

The therapeutic process is just that, a process, but there are often pivotal moments in which the process realizes itself, and where there is a structural change in which everything is now different. The lead has indeed been turned into gold, the monster's energy harnessed. Mary's pivotal scene was the one in which the mountain cave became a place of transformation. When she reached into the cave she was reaching into her own psyche. I can't stress the significance of this enough.

Children naturally flow out into their play. It is them. This natural tendency is intensified in the safe and sheltered play space of therapy, within the context of a positive relationship. Every gesture and play configuration not only expresses, but is, the child. Many years ago I found the following passage in a book, which expresses this well.

> 3,000 years and more ago, men had no conception of those limits which we accept as dividing the world of actuality from the world of imagination. The limits of human and superhuman, material and immaterial were but dimly realized. There was something in common between Gods and men and the beasts of the field and all growing things, and the pathway between the living and the dead… every stream and oak and mountain was the habitation of a spiritual being whose nature was on the borderland between human and the divine and partook of both. And so weak was the sense of identity, that with a touch of magic it was felt that barrier might be passed, and a man might become a wolf or a serpent or a hoopoe or a purple lily. He might renew his youth; he might be raised from the dead…like Melampous, he might understand the language of all living creatures… In childhood we all know these feelings. (Bradford 1963, p.155)

Case example

Eight-year-old James had been adopted from Russia when he was four. His adoptive parents knew that he had been placed in an orphanage at the age of one. The three years he had spent in a Russian orphanage had been hell. The children were terrorized into passivity by stories of wolves and demons lurking outside, ready to snatch them if they cried or called out. There was little or no physical contact and no normal physical release such as comes with tears or anger. James had been a model child for his first few years of adoption and bonded well with his new mother. Then, suddenly, fits of rage would erupt, seemingly unprovoked. James became confused and shaken afterwards, and was at a loss to explain where this rage had come from or what it was about. His parents were devastated, as they somehow believed that they could love him enough that the demons of his past would not emerge. With help they came to see this erupting rage as offering a potential for truly resolving the past.

In his first sand scene James depicted a group of knights on a quest. A large dragon waited around a bend ahead of them. The knights were oblivious to what lay ahead. After several sessions of negative discharge play, James returned to the sand and made the following scene. The same group of knights from scene one was on the same quest. This time, however, the treasure was depicted in one far corner and it consisted not only of gold, but also of a Russian icon. James had buried dragons along the path to the treasure. He then had them erupt from underneath the sand as each knight came towards them. The knights were then depicted rearing back and falling off their horses. It was quite convincing. I felt a strong visceral sensation in my own body as these dragons leapt up out of the sand, even though I had seen him bury them. It was clear that something "big" had happened. When James left, he sat in my waiting room with his mother and wept in her arms for over an hour. This sudden outpouring of tears and the ensuing comfort he received from his mother were precipitated by the dragons erupting out of the sand.

His mother's first reaction to James' seemingly inconsolable sorrow was worry, but it was quickly replaced by the happy realization that her son was turning to her with this sorrow. She sensed that this softening into grief would begin the resolution of his rage and the birth of a more vulnerable and human sense of self. They had entered a new and deeper stage of their relationship.

James's play went through various phases in the coming months as he used the dynamic pictorial language of sandplay to describe and mytho-

logize his life experience. This process of evolution and articulation was very important. The first stage, after his catharsis, was one in which monsters took over the sand, literally pouring over the edges of the box. James was clearly identified with the monsters during this stage. This is a necessary process for many children recovering from trauma. If this was being acted out in one's life, it would be very destructive, but when it is played out in the process of sandplay it is safe: contained by the therapist, the box, the process, and the material. This containment allows it to transform rather than become a part of the child's defense system or personality. By identifying with the monstrous, the monstrous becomes more manageable. We all have these monstrous feelings and impulses within us, simply by the fact of being human. Trauma enlarges these feelings and makes them less tolerable, but also more necessary to confront. James really enjoyed being aligned with the monsters initially, until after several sessions uneasiness became apparent, which signaled a new level of play about to emerge.

James's next stage of sandplay depicted a mountain kingdom ruled by an evil goddess. She had enormous wealth and her realm was guarded by a group of knights. The kingdom would be threatened by other knights in search of the treasure, but they would be easily disposed of in the first of these scenes. The monsters had evolved into a single goddess who was more human, albeit powerful. This reflected a significant evolution in James's psyche as well. The knights aligned with the goddess had an "undifferentiated" air to them, as if they were not yet individuals but rather a collective expression. The knights who were attempting to steal the treasure, in contrast, did seem more individual. I was rooting for them but I had to be patient.

The treasure-seeking knights eventually started to make progress as they got closer to the treasure and began to do more damage. One day the mountain kingdom suddenly disappeared and there were simply two teams of knights, neither delineated as good or bad.

James's personal life was going very well by this point. He had become a much more gregarious and normal child, given to mischievousness rather than rages. He was a positive ringleader at school, rather than a well-behaved but unhappy loner. His early scenes, in which his deeper feelings of rage erupted, allowed him to begin to heal the deep wounds from his orphanage years. This was made possible by the contained and transformative vehicle of the sand and our relationship. The process of contraction into symbolic negativity and the subsequent expansion into positive aggression was real.

Conclusion: the transforming energy of play

There is a profound predilection to experience the joy and vibrancy of life in even the most traumatized of children. This may be buried, or simply coexist with the feelings of shame, betrayal, terror, rage, etc., that we would expect in these children. The acceptance and non-pathologizing of this normal but intense negativity as it is combined with a play process offers the means of discharging it, and slowly but surely brings the positive to the surface.

Case examples

Many years ago a six-year-old child came to see me after her parent's long and very ugly divorce was finally over. They had used her as the object of their "tug-of-war" with each other, and she had been shattered by this experience. She began treatment with a long list of physical and psychological symptoms. She spent many visits sorting out the "her" from the "not her," discharging the negative feelings in her body that had accumulated over time and which had resulted in her hating herself. One day, she began to jump up and down on a mini-trampoline in my office. I began to play on a drum, accompanying her jumping. Then she began to sing. Her song was an angry one, at first, that recounted all the many awful things her parents had done and said. "I hate my mom," she sang in a very sweet voice, "and I hate my dad." This paean of hate went on for some time. As she continued to jump, her song began to change. "I love the sun," she sang, and then "I love the sea." This litany of the things she loved continued until she began at last to sing "I love my life," over and over again. Out of her angry song came this sweet and genuine proclamation of self.

Another child, an eight-year-old girl whose father was dying of AIDS, spent several sessions expressing her anger at her father's imminent death by smashing clay. We had a monster fight in one session, in which we each made monsters out of clay and had them do battle. After pummeling my monster for a while, she then took the clay and began to shape it with her hands. As she did this she spoke of how hard it was to sustain her grief about her father. He had been dying for so long. It seemed to her that her tears had dried up, yet, as she said this, tears began to pour from her eyes. Then we both looked at what she had made, unconsciously, out of clay. It was a multi-tiered fountain! She was as amazed as I was, and asked to take it home. It sat by her bedside over the coming months in which her father's condition worsened. It sat by her

bed for many months after his death, a symbol of her love and the soul's ability to renew.

Winnicott tells us that true therapy happens in the overlap of the child's playing and the therapist's playing (Winnicott 1991). From the confines of this overlap the child is able to leap up, shedding the old and finding a new way. If we are not afraid to let big, seemingly uncontrollable things happen in the child's therapy, then life can and will be renewed. We need to understand the basic need for "no"-saying and opposition as well as self-control, so that we can help to reinstate the natural capacity for love which is our birthright. If we allow and even facilitate form-altering play, such as volcanic eruptions, towers that crash down, clay figures that are smashed, monsters that emerge out of the sand, then children's innate bigness and the closeness in which they still live to the wellspring of life, may help them overcome almost any life experience.

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Chapter 10

Puppetry Interventions for Traumatized Clients

Diane Frey

Given the vicissitudes of life, there are many sources of trauma. The Greek root "traumat-" means "wound."

Terr (1991, p.11) defined psychological trauma as "the mental result of one sudden external blow or series of blows rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations." There are two types of trauma: Type I, in which a single, sudden, time-limited, public and unexpected stressor, such as a natural disaster, might impact a client, and Type II trauma, which is caused by a stressor that results from long-term events such as repeated child abuse (Giller 1999).

Children who have been traumatized often do not have the vocabulary to categorize or evaluate the experience. They often feel helpless and appear like "walking wounded."

Trauma in children is often manifested in flashbacks, repetitive behavior, trauma-specific fear, and limited expectations of the future. The symptoms usually result in feelings of insecurity, powerlessness, hopelessness, and loss of control.

The goal of puppetry for traumatized clients is to help them reach to a normalization of daily life, reactions, and symptoms. Talking through puppets allows children to express their thoughts and feelings by a "distancing" method.

Since these clients are often resistant to discussing the trauma, as in the case of sexual abuse, puppetry can be an effective treatment modality. Some trauma victims, such as those experiencing loss by death, are in denial and are not able to benefit by traditional "talk therapies." Some children are psychologically unaware of the extent and import of the trauma, and therefore

cannot verbalize the event. A two-and-a-half-year-old client who was traumatized by a physical assault (being burned by a car cigarette-lighter while strapped in his car seat) was not old enough to fully understand the situation. Through puppetry, he could express the event more completely. Other traumatized children, such as a five-year-old tornado victim, often do not have the vocabulary to express their feelings or are so traumatized that they cannot talk. Puppetry can be useful to them, as well as to children with special needs, such as those with developmental delays, or hearing or visual impairments.

History of puppetry

Puppetry is centuries old. The earliest reference to puppetry was over 4000 years ago, pre-dating drama and human actors (Bonifacio 2003). In European and North American countries, puppetry became identified with children's entertainment, while in Asian countries it was a serious art form. Puppetry has become one of the most used, but also one of the least understood, of play therapy techniques.

Advantages of puppetry for traumatized clients

Puppets are one of the most useful approaches in play therapy because they are attractive to children and are associated with fun. Puppet use is amenable to a variety of theoretical approaches and is effective across a diversity of cultures. A wide range of expressions, aptitudes, interests, values, and levels of maturity can be expressed through puppetry. It also allows for the experiencing of interdependence. This method is projective and so encourages expression and enhanced communication. Almost all children have access to puppets through home, school, the library, television, or DVD. Even the most reticent client is intrigued by puppets.

A child's sensorial receptiveness is heightened through puppetry. Hands-on puppetry uses visual, auditory, and kinesthetic learning modalities, and by these means enhances and reinforces the learning process in play therapy. Children are usually predisposed to accept and enjoy puppetry because of their past experiences with puppets, and so puppetry is non-threatening to traumatized children.

Most individuals, when discussing events connected to their trauma, find it easier to move from left to right along the following four continua:

others	_____	self
there and then	_____	here and now
thoughts	_____	feelings
comfortable feelings	_____	uncomfortable feelings

Clients, especially traumatized individuals, find it easier (if they are able to use words) to discuss events about others in the "there and then," focusing on thoughts, rather than feelings. If they discuss feelings, it is easier to discuss comfortable feelings, such as joy or happiness, rather than uncomfortable feelings, such as anger or revenge. Traumatized clients seldom arrive in therapy able to discuss uncomfortable feelings about themselves in the "here and now." It becomes the therapist's responsibility to meet trauma clients at their level of readiness and move them, through modeling, across the four continua. Puppetry is very effective in this process.

Clients can discuss the trauma through the puppets. They can discuss traumatizing events in the "there and then." Puppetry, as mentioned previously, becomes a very non-threatening approach for trauma victims. When traumatized clients feel safe with the puppetry experience, they gradually move across the continua to the right side of each continuum. Puppetry helps them make the transition from symbolic play to "talk therapy."

As a result of all these advantages, clients are empowered through puppetry and move closer to the therapeutic goal of being able to verbalize their experience.

Uses of puppets for traumatized clients

There are four basic uses of puppets (Barnes 1996):

1. To allow children to regress to an earlier developmental stage in an acceptable fashion. Due to the trauma experience, victims are often already regressed when they come to therapy. Puppets help them to express their concern in a way that does not embarrass them.
2. To express real and fantasy thoughts, feelings, and behaviors without the fear of being judged or evaluated. The child can project the trauma experience through the puppet character(s).

3. As a role model for clients. Victims will often accept suggestions from a puppet—more so than from a person. (Traumatized children have often developed a mistrust of people.)
4. To increase communication. Children who are reluctant to speak directly to adults or other children in individual or group play therapy will often express their needs through puppetry.

Selecting puppets

Several criteria for puppet selection are important when treating traumatized clients.

1. Children should be able to manipulate the puppets easily.
2. Puppets should have small enough openings to fit children's hands.
3. Different textures of puppets are important.
4. Puppets should be washable or dry-cleanable. They should also be durable.
5. Do not choose puppets with universal symbolism, such as Santa Claus or Big Bird; these puppets lack the projective value of puppetry because children express the stories they have been told about the character, rather than their own dynamics.
6. Puppets can be made from paper bags or from human hands, by painting on them.
7. Purchased puppets can be finger- or hand-puppets.
8. Puppets should represent a variety of dynamics and affects, such as
    - cute and cuddly (kitten, dog, lamb)
    - aggressive (shark, alligator, dinosaur)
    - royalty (king, queen, prince, princess)
    - witch and wizard
    - angel and devil
    - police officer, rescue worker, judge
    - owl, clam, and turtle.
9. Human figure puppets should be racially appropriate.

10. Approximately 15 to 20 puppets are recommended. Too few puppets does not allow for enough range of expression; too many creates too many choices.

Animal puppets and fantasy puppets enable traumatized children to discuss concerns more readily, since such puppets represent "others" on the communication continua reviewed earlier. Through the process of therapy, children eventually choose human figure puppets.

Developmental considerations

Pre-school children tend to be less verbal in play and more action-focused. Such children have uncensored play. Since they are not able to use repression yet, their play lacks disguise and has a high degree of clarity.

Case example

A two-years-and-nine-months-old client was burned in ten different places on his body by the seven-year-old son of his babysitter. The children were locked in the babysitter's car while she did some banking, and the seven-year-old burned the boy with the car cigarette-lighter. The child was so traumatized that he ordered complete strangers not to burn him.

When entering the playroom he spontaneously chose a horse puppet. He told the therapist that the horse puppet had to go to the hospital. The horse puppet told of ten "ouches" he had. As the child played out the traumatizing event, there was completely uncensored play that exemplified a correlation to his real life experience. In fact, he spontaneously stated with amazement that the horse was just like him.

Latency-aged children (ages 6 to 12) have usually developed coping defenses. Their manner for dealing with conflicts is through symbolism and fantasy. Since puppetry approaches are symbolic and involve fantasy-oriented themes, this play therapy medium is ideal for latency-aged children.

Case example

A ten-year-old client was traveling in the family car with her mother when a very large, old tree was hit by lightening and fell on top of their car. Both mother and daughter were hospitalized, and the car was totally demolished. After the trauma the child would not separate from her

mother. She would not go to another floor of the house without the mother being there also.

Upon entering the playroom in the third session, she decided to play with the finger-puppets. The dog puppet wanted to go to school. In the process of trying to go there, he was threatened by a poisonous snake puppet that tried to bite him and a lion puppet who tried to eat him. Finally, the dog puppet retreated and went home.

The contrast between the pre-schooler's puppet play and the latency-aged child's puppet play is evident. The pre-schooler was much more direct, kinesthetic, and uncensored. The latency-aged child's play was more symbolic and fantasy-oriented.

The process of puppetry

The child relaxes his defenses in puppetry and accepts into his consciousness ideas and feelings that help him try to cope with conflicts. The symbolism of the puppetry helps the traumatized client to self-disclose and heal.

Some puppet play evolves casually when children initiate play between and among puppets, with or without therapist interaction. Puppet play can also involve structured activities, such as making up a puppet play.

In more structured puppet play, there can be several stages of play. First, there is the selection of puppets, followed by the warm-ups, the playing, the post-puppet interview with the puppet characters, and finally, the post-puppet interview with the child.

In the *puppet selection process* for a puppet play, children are shown a number of puppets (15 to 20, fewer if the child is younger than six). Children are asked to select some puppets for a play and then to introduce each character. It is noteworthy which puppets are chosen and which are rejected. Therapists can ask the puppets some open-ended questions, such as "Tell me a little bit about yourself."

The child is encouraged to prepare for the story in the *warm-up stage*, and the stage is set for make-believe play. The therapist responds directly to the puppets, never to the child.

The therapist is the audience during *the puppet show* and occasionally asks open-ended questions, if these do not interfere with the momentum of the play. Usually the therapist does not participate in the play unless asked, and only if such participation would be facilitative. The therapist can prompt plot

development by saying "and now…" and/or "and next…," in a way that encourages the child to be her own imaginative self.

In the *post-interview with the puppets*, the therapist talks to the puppets. Focus is on form and content while the therapist tries to understand the symbolic meaning. In the *post-interview with the child*, the latter can talk directly about the experience. The child is asked what he liked best about the play, what he liked least, what might be changed, and with whom he identified. Sometimes the therapist might ask the child to give the play a title and to tell her what is the lesson or moral of the story. This can reveal to the therapist the major concerns of the child. Children can also be asked what they would change about the play if they were to do it over again, or if a fairy godmother could magically change things.

Throughout the processing stages of the puppet play, the therapist analyzes the form or "how" of the story (creativity, coherence, ego control) as well as the content or "what" of the story (characters, environment, plot, themes). The therapist also analyzes the coping styles that are revealed and the major conflicts that are presented in the play.

An additional technique of puppet play is the incomplete sentence. There are several variations of this approach. The easiest and most direct is for both the therapist and the child to choose a puppet. The therapist's puppet states a sentence stem and the child's puppet responds. Therapists choose initial sentence stems which are non-threatening, such as "When I get up in the morning…," "I like to…," "My favorite television show is…" As the process continues, the therapist states more challenging sentence stems such as "I am sad when…," "The worst thing about me is…," "My biggest wish is…" Therapists choose stems which are relevant to the feelings and trauma the child has experienced. Content can be analyzed in the same manner as the puppet play.

Puppetry experiences can also be videotaped. Children are usually eager to view their tapes which serve as mirroring devices that allow children to see the puppetry reflected back to them in a non-threatening way.

Group puppetry for traumatized children is quite useful, as is family puppetry for families that have experienced a trauma. The therapist is able to identify the various sub-groupings of the family by this means, and to observe their methods of support or non-support for each other. The therapist can learn (in addition to what would be processed in individual therapy) the stages of trauma response which each family is experiencing, as well as the pattern of how loss is experienced by each family member.

Case example

Eight-year-old Alicia was referred to therapy by her adoptive parents. Both of her natural parents were declared "unfit" by the legal system. Her parents were found guilty of physical abuse, sexual abuse, and emotional abuse. Alicia was removed from them and placed in foster care. After being adopted, she was referred to therapy but refused to discuss any of the events. She had not mentioned any of the precipitating events while she was in foster care. In the seventh therapy session, she initiated a puppet show with puppets she had previously examined but had only played with briefly.

In contrast to the puppet show stages previously mentioned, this puppetry experience was spontaneous and free-flowing. Alicia used a queen puppet and instructed the therapist to use a princess puppet. The queen puppet was demanding, authoritarian, and deprecating to the princess puppet. The child coached the princess puppet (therapist) in what to say to the queen puppet. The queen demanded that the princess clean the whole castle, and criticized the princess for her every action. The princess was instructed to ask the queen if she would make breakfast for her in the morning. The queen replied that she would get no breakfast, in fact she might get a beating if she continued her behavior. The queen began to drink beer and became more abusive. Without any warning Alicia put down the queen puppet and became the princess puppet. The princess began a soliloquy about her hurt feelings. She told the queen how mean and terrible she was. Finally, she told the queen she would never be like her when she grew up. She was going to be a good mother, a caring and loving mother who did not get drunk and beat her children. She was not going to say mean things to her children. The princess puppet was going to love her children and give them attention, kisses, and hugs. She reiterated several times that she was going to be a *good mother*! All the time that the princess puppet was saying these things to the queen, she was pointing her finger at her and was literally "in her face." This marked the end of the puppet show.

Alicia then asked the therapist if she could do this show for her adoptive mother, who was in the waiting room. The therapist prepared the mother for the show, delineating that the mother in the show was not the adoptive mother but symbolized the birth mother. The child and therapist repeated the show with the same emotional intensity.

This puppetry play enabled this traumatized client to reveal her hurt, anger, and disappointment in her mother for the first time. The choice of

a fantasy puppet made it safe to express her feelings. She obviously wanted to share these feelings symbolically with her adoptive mother. The puppetry served as a catharsis for this child. Her puppet play was typical of her age because it was symbolic and fantasy-oriented.

Case example

In another case, a five-year-old boy was referred to therapy because he had witnessed his entire house being blown away in a tornado. He also saw his older sister being decapitated by flying glass during the tornado. Before the storm he could recite the alphabet, count to 100 and state at least 20 different colors. After the tornado he could do none of this.

During the third session he was asked to do a puppet show. He chose to do a show about a tornado, although he previously would not talk about the tornado. During the puppet selection stage he chose three human figure puppets: a mother, father, and son. (This was isometric to his current family condition, a mother, father, son, and deceased sister.)

The show's theme was about the anticipation of the tornado, the actual tornado experience, and the aftermath of the tornado. In the aftermath stage of the show, the son puppet expressed his feelings of loss and cried about his sister. The puppet show exemplified the developmental considerations previously reviewed in this chapter (for pre-school age) inasmuch as the play was very direct, action-oriented, uncensored, and had a high degree of clarity.

During the post-interview with the puppets and the child, more of his feelings of loss of control and anxiety were revealed. In this stage of the trauma experience the child was more capable of responding to how the puppets felt than to how he felt himself. Subsequent puppet plays revealed more and more of the child's feelings during the post-interviews.

Case example

A 12-year-old client witnessed her mother stab herself in the stomach. The mother was addicted to prescription medications for pain. She was so desperate for pain medication that she announced to her husband and daughter that she was going to stab herself in the stomach so that she would be rushed to the hospital and given a morphine drip. A few days later the mother actualized the plan in the presence of the daughter. A

week later, after she returned from the hospital, the mother died of an overdose on the living room sofa.

By the time the girl was referred to therapy five months later, her grades had dropped from A's and B's to D's and F's. She had changed her friendship group to a group of fairly undesirable students, and her father was not discussing the death with anyone, including his daughter.

The client could not discuss her loss directly with the therapist, but did show some interest in the sandtray and puppets. The therapist encouraged her to create a puppet show according to the stages previously mentioned. The girl selected three animal puppets; although not stated, each represented a family member: mother, father, and daughter.

The show's theme was about a happy family for whom everything suddenly went bad. The mother died and the father was physically and emotionally distant from the "baby." The baby took refuge in other baby friends but did not reveal to them what troubled her. The baby felt astonishment, hurt, and a "deep hole in her heart." In the post-interviews with the puppets it was revealed that the baby wondered if she would face the same fate as the mother someday. In the post-interview with the child some of the same feelings were disclosed, and the same anxiety about whether she would become addicted.

The title of the story was "Bad Supervision." The moral of the story, as told by the client, was "using words helps." The therapist concluded that, through the puppetry, she had just begun to realize that "using words helps."

Conclusion

For traumatized children many symptoms are unconscious, nonverbal, right-brained experiences that often cannot be accessed through talk therapy. Puppetry methods provide a safe, structured medium to re-enact the trauma so that healing can begin. Puppetry is a direct-action method through which the child's internal reality is recognized and tangibly seen by client and therapist. It is then that healing begins.

Trauma is a fact of life. It is not a question of whether or not trauma has been experienced by a child; it is about what to do when trauma happens. When clients can realize that "life goes on" and they can reframe the trauma into a life lesson, healing has occurred. Puppetry is a very powerful technique to help traumatized children become empowered.

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Chapter 11

Video Play Therapy

Diane Frey

Have you ever viewed a movie and found yourself having an intense emotional reaction? Have you found yourself discussing the movie with others days later? If so, you have experienced reel life to real life. The transformation from reel life to real life can happen through discussion and/or play therapy.

Definition of video play therapy

Video play therapy is the process in which clients and therapists discuss and play out themes and characters in films, which relate to the core issues of their therapy. In video play therapy a bond develops between the viewer and the film. In the very best films, viewers often experience a dissociative state in which everyday existence is suspended. Films have a greater influence on individuals than any other art form.

Nothing conveys information or evokes emotion quite as lucidly as the visual sense. Filmmakers capture that visual sense and combine it with sound to create movies. Movies are the most engaging form that we have of mass communication (Kernberg 1994). Films are an integral part of our culture. The proliferation of VCRs and DVDs have expanded the influence of this medium.

History of video therapy

Therapists have long recommended books, plays, poetry, and visual and performing arts as a method to teach mental health concepts and facilitate enhanced emotional experiences. It was not until the 1930s that bibliotherapy was prescribed for clients. The Menninger Clinic bulletin (Menninger 1937) describes how literature could serve therapeutic

purposes. More recently, non-fiction, in the form of self-help books, has been used by therapists.

Video therapy is an extension of bibliotherapy inasmuch as it shares the same goals, advantages, and limitations. It differs from recent bibliotherapy approaches in that video therapy uses primarily fiction rather than non-fiction. Films offer a wide range of interpretations determined by the clients' needs. The therapist offers guidance and connections that help the client to understand the underlying dynamics.

Video therapy differs from bibliotherapy in terms of therapeutic approach. Bibliotherapy is used to reinforce ideas introduced in therapy. Video therapy is used to encourage introspection and insight by the client. As clients watch films, they identify corresponding information that may not have emerged in therapy sessions.

Two viewers rarely have the same experience when viewing a film. Each one has his/her own perceptual framework. This subjectivity selects, attends, and translates into the client's unique view of the film story—another way in which video therapy differs from bibliotherapy.

When assigned as "homework" in therapy, video therapy is more readily accepted by clients, since it is usually more entertaining for most clients to view a film or video than to read a book. Clients who might read a *single* book during treatment will more than likely watch several films which relate to their issues.

Unique aspects of video therapy

Films and videos can weave fantasy and reality together. Processes such as thinking, imagining, recalling, and feeling are not visible, but through the language of the montage, the camera techniques suggest these psychodynamics. Flashbacks and parallel actions are identified with thoughts, feelings, and behaviors of the characters in a video in a way that cannot be expressed in other media. Unconscious motivations and defense mechanisms can be portrayed through film much more than through other media.

Video play therapy

The process of video therapy is essentially the same as bibliotherapy except that the therapist might suggest watching only segments of a video at a time, due to a child's shorter attention span, dependent on her age level. With adolescents and adults in play therapy, the entire film or video might be viewed. The therapist and client might decide to re-enact segments of the video

using puppetry, sandplay and/or dress-up clothes. Children sometimes draw their responses to the video. Children can also make their own video where they act out relevant parts of the video using dolls, stuffed animals, or other play therapy objects.

Trauma and video play therapy

Traumatized children who are reaching adolescence and adulthood are at an increased risk for substance abuse, suicide attempts, delinquent behavior, and personality disorders. It is extremely important, therefore, that these children receive early interventions.

Traumatized children often find it very difficult to discuss their trauma using traditional "talk therapy." These children experience such high levels of anxiety that they are often unable to talk about the trauma, so they resist traditional "talk therapy." They may have been told to "never tell" anyone about the trauma (abuse, for example), or they may be resistant to the therapeutic process for other reasons. Some traumatized children (children who have experienced natural disasters or witnessed a death) dissociate, and consequently are in denial about the trauma. They are unable to "talk" directly in traditional therapy.

Many traumatized children have limited language ability, and video play therapy is an excellent treatment modality for them, as it is for children with developmental delays or those that are speech impaired.

Video play therapy is an excellent treatment modality because it gives these children choices and enables them to feel more in control and less anxious. The unpredictable and unknown aspects of treatment (at least from a child's viewpoint) tend to make some children even more fearful and anxious. Because video play therapy has a certain structure and format, it offers a child more comfort.

Advantages of video play therapy

Children, adolescents, adults, and clients of diversity have positive associations to movies and videos or DVDs. Even the most resistant client will respond positively to this medium. For clients of diversity, videos can often be obtained in languages other than English.

Clients accept information through videos that they will not always accept directly. Children who cannot accept a loss will often do so more readily through this modality. Traumatized clients can confront the abuser more easily through video play therapy.

Case example

> After viewing a segment of "Cinderella," a six-year-old girl who was a victim of physical, sexual, and verbal abuse used dress-up clothes to re-enact a scene. She instructed the therapist to play the role of the wicked stepmother. The child confronted the therapist/stepmother about what a terrible mother she was. She stated several times that she would be a loving mother when she grew up. The video viewing and re-enactment in play therapy gave the client the impetus to say what she had wanted to say to the perpetrator.

Video play therapy leads to shorter treatment, and greater insight about client dynamics and the dynamics of significant others. In an age of managed care, this is a definite benefit to all concerned.

Children experience this form of therapy as fun. It helps in building rapport and a therapeutic alliance and creates a triadic relationship between the child, the video, and the therapist. When two people view an event and understand it from a similar perspective, empathy is increased. Children begin to feel that the therapist really does understand the traumatic experience in ways that they cannot express.

The client takes an active part in video play therapy in contrast to more traditional forms of therapy. The therapeutic process is strengthened by the learning modalities of visual, auditory, and kinesthetic channels.

When video replay is used, the client is given the unique opportunity to clarify events through repeated detailed and meaningful re-experiencing. Such repeated playbacks, done in a therapeutic environment, can reduce and/or eliminate denial.

Compliance in therapy is increased through the use of video play therapy because this approach is novel to clients and the experience is usually positive. Clients often suggest other videos with similar themes that they would like to re-enact. These can also be acted out as a puppet show or in the sandtray or some other modality of play therapy.

Video play therapy can also be used in group play therapy sessions or in family play sessions. Clients use dress-up clothes and/or puppets or group drawings relative to a particular therapeutic theme, or they can choose to make their own video.

In the Cinderella case mentioned earlier, the child wanted to play out the scenes she had done with the dress-up clothes for her foster mother. This was the child's way of communicating to her foster mother in a safe way about

her abuse experiences. She had refused to talk with anyone about the experience before she viewed that video segment.

Uses of video play therapy

Video play therapy is used to enhance self-perception of traumatized children. It can also be used to foster attitude change and to help clients gain insight and increase their motivation to change. The traumatized girl mentioned above was not only able to tell her story to her foster mother symbolically through the video play therapy; she was able to experience a significant catharsis as well.

The universality of human suffering and conflict can also be understood through video play therapy. When children view *The Lion King*, for example, they begin to understand that all creatures experience loss and grief.

This modality can also infuse clients with hope and optimism for their life situation. In video play therapy adolescent clients of abuse can realize through watching *Good Will Hunting* that "It is not your fault," and they can go on with their life in a productive, successful manner. Such clients might be able to draw their reaction to the film and/or re-enact this in a sandtray.

Finally, video play therapy enables traumatized clients to have a healing experience. Experiencing the artistic resolution of another's trauma can provide the viewer with a sense of relief.

Contraindications

Clients with serious psychological problems are often unable to distinguish reality from fantasy and are not good candidates for video play therapy. Clients who have *very* recently experienced a trauma are not good candidates for this approach because it can have intense emotional content.

When the client does not like a video the therapist has chosen, or finds the main character unattractive, it is best to select another suitable video or, if none is available, one might switch to another modality. This holds true if clients have objections to videos due to religious or cultural values.

Therapeutic viewing

The process of video play therapy is not the same as viewing films or videos for entertainment. In entertainment, viewers pay more attention to the plot. In play therapy, the focus is on the character and the relationships. What is most important is the process of change in relationships. Clients are able to

play out how the character(s) change for better or worse and how the character(s) feel in response to these changes. For example, how does Simba change in the film *The Lion King*, when he realizes that his father has been killed? How does he feel? What behavior of Simba's would the client like to adopt? What attitudes of Simba seem to be helpful? Is Simba's approach to problem solving similar or dissimilar to the client's? (These similarities or differences could be shown through drawings or puppetry.)

Another difference between entertainment viewing and therapeutic viewing is the emphasis on process rather than outcome. To continue with *The Lion King* example, the client might be asked to play out her ideas for coping. What could she learn from Simba's process of grieving?

The focus on insight development is another difference between viewing for entertainment and viewing for therapy. When viewing for fun the emphasis is primarily on excitement, whereas in therapy the focus is on insight.

Casual viewing involves a focus on "movie stars" where the emphasis is often on suspense. When viewing for therapy, the focus is on analysis. Clients are asked to analyze the characters' behaviors and apply them to themselves.

How to select videos

There are several criteria for selecting videos for play therapy of traumatized children and adolescents.

The therapist needs to select videos that portray effective role models. Sometimes the role model a child needs is not available in real life but is available in *reel* life. The primary issue for the therapist is whether clients can project themselves into the role model. The therapist can conceptualize an ideal role model and then choose a film which showcases such a person. The closer the model resembles the client, the better. *The Lion King* is the ideal for a client who has loss issues, especially related to death. The role model is someone like Simba who has to struggle with and overcome the same issues as the client.

Clients can be influenced by negative traits of the character as well as the positive ones. In such cases the therapist can process the pros and cons of the video character and the resultant behavior in different puppetry scenarios.

The play therapist should match the content of a video to the client's therapeutic issues and try to match the client's circumstances (as much as possible) in chronological age, socio-economic background, education,

values, and subject matter. Many videos are available about trauma topics such as loss, grief, divorce, anxiety, substance abuse, and death and dying.

Choose films which clients enjoy. Therapists can make suggestions, but often children have favorite videos. Very likely these videos are favorites because they are meaningful to the client's psychodynamics. Many children watch *The Lion King* over and over because there are many lessons to be learned about trauma from this video. Clients communicate to therapists symbolically through their choice of videos and their focus on the various events and dynamics that are portrayed.

Case example

An 11-year-old gifted client once enthusiastically expressed that his favorite video was from *The Twilight Zone*, entitled *A Stop at Willoughby*. Since he expressed this with such intensity, the therapist viewed the video. The main theme of the video is about a very over stressed man who wishes for some peace in his life. The surprise is that in the granting of his wish, the man finds himself deceased. The most interesting element of this therapist–client interaction was that this character felt that he was very stressed and that he wanted to find relief. Although the client did not wish to be deceased, he realized that something in his life needed to change. He did not express this directly to the therapist. However, when asked to play this out in the sandtray he mirrored the same theme of being distressed and then sinking into quicksand or else being blown away by a tornado. He had no idea how to change his stressful lifestyle. The therapist and client made a video about a boy who was overstressed, in which the therapist embedded several coping strategies. Client and therapist viewed the video and then processed how these techniques could be used.

Another selection guide for therapists is to choose videos which portray characters solving problems. Films and videos are ideal metaphors for problem solving because they include thesis, antithesis, and synthesis. The characters experience a problem, try out many unsuccessful responses, and eventually find a pro-social solution. Ideally, clients do the same. In the film *Rudy*, the character wants to play football at Notre Dame even though he does not meet the criteria for admission for playing university football. He tries many tactics unsuccessfully and eventually succeeds. He has experienced the trauma of losing his best friend in an industrial accident, which

spurs him on to attain his goals. This film has been invaluable in helping clients change trauma into a salutary experience.

When selecting videos, therapists can also choose videos which use powerful indirect suggestions. Hollywood films are often more therapeutic than client educational or didactic films simply because the message is more indirect and client resistance is minimal. The message in these films is often embedded in the context of an unrelated story. For example, a four-year-old client once expressed that her favorite video was *Scooby Doo.* When asked what she liked about it, she said that she liked how Scooby Doo always solved the mystery. This message is embedded in the video but is not the main content. This girl wanted to solve the mysteries of her own life, where there was a lot of confusion about whether she had been sexually abused at the age of two. Adversarial divorced parents had argued about this for two years.

One other criterion for video selection is to choose those which invoke inspirational moods. Such videos evoke a sense of healing, well-being, and hope. *Rudy*, *Jonathan Livingston Seagull*, and *The Fall of Freddie the Leaf* are a few that can help trauma victims experience a feeling of peacefulness. Mood evocation is a key element in video play therapy.

With these guidelines in mind, therapists should develop a list of therapeutically useful videos for play therapy. They also should be aware of films currently playing in theaters that are an active part of children's lives. Flexibility in choice of videos is important. Sometimes videos which therapists find useful, clients do not like, and vice versa. If therapists watch films with these criteria for selection in mind, their database will increase. Keeping client video favorites in mind will also augment the therapist's list of choices.

The process of video play therapy

After carefully choosing a therapeutic video or segment of a video for a client, the therapist usually suggests to the client a relationship between the video and the client's life experience(s). This may be done by simply saying, "Let's watch Simba [*The Lion King*] and see what we can learn from him." As a child has a limited attention span, as mentioned earlier, segments of a video can be used instead of an entire video. Segments are sometimes used with adolescents and adults, but they could also be assigned to watch the entire video outside the therapy session and process it later.

After seeing the chosen film or segment, the child and the therapist play out different aspects, with the child taking the lead as to what he wants to focus on from the viewing.

Case example

A four-year-old boy who was referred for therapy due to the sudden death of his 24-year-old father was shown the segment of the video *The Lion King* in which Simba realizes that his father has been killed. Prior to seeing this video, the child would not speak to anyone about the trauma. (He did suffer from repeated nightmares.) After he saw the video, the child chose to use dress-up clothes to be Simba and instructed the therapist to be Simba's father. The play-acting continued until the child came to a natural stopping place. The therapist then processed the video and play therapy by discussing in what ways Simba was similar to and different from the client. The therapist discussed with the child what attributes of Simba he would like to have. "What aspects of the character in the video would you like to avoid?" was another process topic. The therapist and the child discussed how he could use Simba's strategies to meet the challenge from his trauma.

Video play therapy does not always take the form of dress-up clothes. A child might draw how she feels after viewing the relevant video, or do a puppet show or a sand picture. These are some examples of transferring reel life to real life. It is also possible to use dolls, trucks, pipe cleaners, play guns, and other play therapy materials that help a child transfer the video plot to a symbolic plot in play therapy, and ultimately to the child's real life.

Watching a video segment or video is not in itself therapeutic—it needs to be processed. While viewing the video and then playing out various aspects and generalizing them to the child's actual life, several process questions can be beneficial to the therapeutic process:

1. With which character did the client identify?
2. How is that character similar to or different from the client?
3. What aspects of the character would the client like to adopt and what aspects could be avoided?
4. Who was the antagonist and what barriers did he or she present?
5. How did the protagonist overcome the challenge?

6. How can the client use similar resolutions or problem solving for his challenges?

In addition to the play therapy modalities just mentioned, video replay is another useful tool for processing. In this procedure, the client and therapist make a video of their experience of the video and play it back. Still another method would be to make a video of the client in the role of the character or self and, through playback, the therapist and client confront cognitive errors of the character or the child's thinking about the trauma. In this way the child receives feedback about his thoughts or behaviors in a less threatening manner than by direct feedback.

Successful treatments for traumatized children have been stress management (including positive self-talk, thought stopping, relaxation methods), psychoeducation (labeling feelings), exposure—storytelling about the trauma—cognitive reprocessing (correcting cognitive errors), and parental treatment. All of these successful interventions can be incorporated through video play therapy.

Client processes in video play therapy

While the therapist is focused on the aforementioned process content, the client usually experiences four stages in video play therapy:

1. identification—clients see the similarities between the character(s) in the video and themselves
2. catharsis—viewers allow emotions and conflicts to come into consciousness
3. insight—clients identify the connection between the character(s) and themselves
4. universalization—viewers understand that their conflicts are not unique and that they are capable of adopting new coping strategies.

Case example

An 11-year-old client was referred to therapy because she and her two older brothers had found both their parents dead in the family kitchen. The father had killed the mother and then shot himself. The girl had previously been in traditional "talk therapy," during which time she would not discuss anything about the trauma. Video play therapy was used with

her. The suggestion was made that the therapist and child could view parts of *The Lion King*. (The therapist had discovered that the video was a favorite of the client.) The child chose to draw Simba and to talk about Simba's feelings upon discovering that his father had been killed. She then drew a picture of how Simba might have felt if both his parents had died (*identification stage*). She later drew her own feelings about the death and suggested doing some puppetry using lion puppets. During this time the lion puppets experienced their feelings about death (*catharsis stage*). In later sessions, the client asked to see the previously viewed video segments. She played out her actual trauma scene in the sandtray (*insight stage*). Finally she staged a puppet show in which the main character (herself) evidenced new coping strategies (*universalization stage*).

This process flowed entirely from the video play therapy. *The Lion King* helped to give this client hope and encouragement and helped her to reframe her conflicts, while providing her with a role model for effective coping. This method helped her to identify and reinforce her internal strengths and to increase her communication about the trauma. The affective realm was addressed by this film in such a way as to potentiate her emotions. Her feelings were galvanized, while at the same time she gained new insights. The cognitive insights helped her to understand what behavior she needed to change, and the affective insights gave her the motivation to effect these changes.

In the concluding stages of therapy, this client suggested that we make our own video, entitled "The Lion Queen." It was populated with people from her family and she did not use animals. The video was individualized by the child to fit her current life situation. She and her grandfather (who was parenting these children) and the therapist viewed it together. The therapist then guided the processing. When the client said, "You never get over it [death] you only get through it," the therapist realized that termination was near.

Dr. Phil McGraw often states, in the popular television show named after him, that the most important part of the show is *after* the show. When the participants view the video of the show, it is then that they begin to develop insights and make commitments to change.

Termination

Two important elements need to be addressed when terminating video play therapy. The therapist should focus, first, on achievements made by the

client, and second, on how to maintain these achievements. This can also be done through repeating the segments of a video which focus on these issues, through puppetry, sandplay, drawing, or dress-up clothes.

Conclusion

One of the unique characteristics of video play therapy is that viewers glean from the video that which is applicable to them from their individual perspective. Video play therapy is a technique in which "a child can wade and an elephant can swim"—each individual brings his or her unique interpretation to the experience. This very fact is what makes many successful films meaningful to individuals of all ages: children experience the film at their level, and adolescents and adults experience it at theirs. Video play therapy has been found to have a very successful effect on clients. While more research needs to be conducted into the efficacy of this approach, the clinical findings to date are positive.

> Through the arts, we transform not only our joys, but also our tears and anguish, paralysis and fears, and the unexplained and mysterious into images of strength, clarity and control. (Steinhardt 1994, p.217)

This is truly what the goal of video play therapy is for children, adolescents, and adults in trauma.

Appendix 11.1: Video play therapy suggestions for trauma

The criteria mentioned previously serve as a guide for therapists selecting videos. The following videos are some common ones that are useful:

- *Corrina, Corrina*: a withdrawn eight-year-old's mother dies.
- *Fly Away Home*: an adolescent's mother dies in a car crash.
- *Ponette*: a four-year-old child tries to understand the death of her mother.
- *Unstrung Heroes*: a young boy fears his mother's death due to cancer.
- *Ever After*: a girl learns to deal with her mother's death and adjust to a difficult stepmother.
- *The Brave Little Toaster*: a group of household appliances learn how to deal with their fears.
- *The Lion King*: lions learn to overcome their fears and take on responsibilities.

- *Jonathan Livingston Seagull*: teaches the power of love and how to deal with spiritual concerns.
- *Good Will Hunting*: a young man tries to deal with an abusive past.
- *Rudy*: a young man sets out to achieve his goals. He is partially motivated by the death of his friend.
- *Tuesdays with Morrie*: a college professor shares his life insights while he is dying of ALS (Amyotropic Lateral Sclerosis, also known as Lou Gehrig's Disease). (For adolescents and adults.)
- *The Five People You Meet in Heaven*: an introspective look at the meaning of life (for adolescents and adults).
- *Mommie Dearest*: a film about the pathological relationship between a mother and daughter.
- *Wizard of Oz*: all four characters are searching for qualities they already have.

This is only a partial list of videos which deal with trauma issues. Many Disney films have excellent coping strategies for various trauma situations.

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Chapter 12

The Bowl of Light
A Story-Craft for Healing

Joyce Mills

Introduction

A "story-craft" is an activity that is founded upon a story or myth. It expands the storytelling metaphors into a tangible form, thereby deepening the healing potential on a conscious and unconscious level. The Bowl of Light "story-craft" was developed in response to Hurricane Iniki, which ferociously struck the Garden Island of Kaua'i, Hawai'i, on 11 September 1992. It became one of the numerous natural healing activities developed for the children, adolescents, and families living on the most remote side of the island as part of the Westside 'Ohana Activities Project, funded by the Office of Youth Services through Child and Family Services, Kaua'i. At the time the grant ended, there were a reported 4000 bowls of light made by those living in the Westside community. Since then, I have presented the story internationally to individuals and communities who have experienced extreme trauma from both manmade and natural disasters. Additionally, the Bowl of Light story best describes the philosophies inherent in a new multicultural model of therapy I call StoryPlay®, which uses the foundation of metaphors, storytelling, and play, along with the principles of Ericksonian psychotherapy and indigenous teachings. This chapter and exercise is adapted from my book, *Reconnecting to the Magic of Life* (Mills 1999).

The Bowl of Light story-craft can be used with individual children, adolescents, families, or culturally diverse communities. It can also be utilized in a variety of settings, e.g. the playroom, classroom, hospital, or community center.

Part one: the story

With straight, brown hair loosely dangling down the sides of her face, frail-looking Jaimi sat curled up in a beanbag chair, separated from the other girls in the group. Every time one of the girls spoke, Jaimi would roll her eyes as if to say, "Oh paleeeze," huffed a bit, and stayed securely curled up, like a snail being approached by a potential predator. By the tender age of 15, Jaimi had wound up in gangs, a runaway, and covered her sadness, anger, and feelings of hopelessness by cutting herself with pencil points and scraping her skin with paper clips. Like too many of our children today, Jaimi was a teenage girl who had been severely abused and neglected and bounced from foster home to foster home. Eventually, she ended up at the residential treatment center in Oregon that I visited every year between 1987 and 1996, where I worked with the children and staff, using storytelling and rituals for healing.

On this particularly breezy fall afternoon in 1993, we gathered in a large, cozy living room with overstuffed couches, big, flower-printed floor pillows and a few beanbag chairs comfortably placed in front of a deep stone fireplace to *talk story*, as we say in Hawai'i.

After about an hour of interacting with the girls, they asked me if I knew any good Hawai'ian stories. After thinking a bit, I remembered an ancient Hawai'ian story I found in the book *Tales of the Night Rainbow*, as told by Grandma Kaili'ohe Kame'ekua to her grandchildren, Pali Joe Lee and Koko Willis (Lee and Willis 1990). All the girls in the group gathered closer to hear the story…all except Jaimi. With arms tightly wrapped around her knees, she remained curled and distanced. Nonetheless, I began in the way that I best remembered the story:

> Once, a long time ago, there was this wonderful old grandma who lived on the tiny Island of Moloka'i. Her name was Kaili'ohe Kame'ekua and she was over 100 years old when she died in 1931. Grandma Kame'ekua and her family taught the children by stories, ancient chants, and parables. One story that was *reeeally* important to her '*ohana* (which means "family" in Hawai'ian), is that every child is born with *a bowl of perfect light*. If the child takes good care of the light, it will grow and become strong. The child will be able to do many things, such as swim with the sharks, and fly with birds, and the child will be able to know many things. However, sometimes there are negativities that come into a child's life… There are hurts, angers, jealousies, or pain. And these hurts, angers, or pain become like stones that drop into the bowl. And pretty soon there may be so many stones you cannot see the light… and pretty soon the child can

> become like a stone, he or she cannot grow…cannot move. You see, light and stone cannot hold the same space. But what Grandma Kame'ekua tells us is that all the child needs to do is turn the bowl upside down and empty the stones and the light will grow once more … Yes, the light *is* always there.

When I had finished the story, 14-year-old Mabel spontaneously said that she thought about her own abuse and use of drugs as a way of coping with her life's pains, struggles, and challenges. She said, "This bad stuff that happens is like the stones in the story. It just takes away the light." Sixteen-year-old Hannah said that she felt that the story talked about self-esteem: "like the bowl of light is like the pretty pockets we have inside us." I listened with an open heart as the girls processed what the story meant to each of them.

Many were visibly touched by this story, but I did not know how much the story touched one particular girl until a few minutes after the group had ended. It was Jaimi, the girl in the beanbag chair. With her therapist by her side and with soft tears beginning to stream down her cheeks, Jaimi said, "Aunty Joyce, all my life all I ever see are clouds of darkness, but after hearing that story, a crack of light went through the clouds and I *know* that I am going to be alright." As Jaimi spoke, she used her shaking, pointed finger to draw in the air a crack piercing the darkness. Jaimi's gentle tears then released into strong sobs while she said that she had been suicidal and had just about given up hope of ever being okay. Jaimi went on to say that all she ever felt was anger about the abuses she had endured throughout her life, feeling like she was powerless to make the changes she needed to be happy. But when she heard the story, she knew that she could "empty the stones from my bowl," and most important, that there *was* a bowl of light for her.

Through her sobs, Jaimi's affect changed from hopelessness to determination. She decided that she wanted to make her own bowl of light out of clay and gather her stones, which would represent her pain, anger, and abuse. The light was clearly beginning to glisten through the darkness of Jaimi's life.

Jaimi's bowl of light

On my return visit about six months later, Jaimi was excited to show me the bowl she had made, along with the stones she had collected. She invited me to go with her to find a place to empty her stones—literally. I felt honored to be included and agreed without hesitation. It was a

delightfully moist Oregon day when we walked down the pine-tree-lined road that ribboned through the grounds of the treatment center. As we walked, Jaimi proudly told me about the changes in her life since she first heard the story: she was able to go to a regular high school, to make friends, and she was even able to go on a date. Chuckling a bit, she said, "I'd forgotten how good a Baskin Robbins hot fudge sundae is!"

Jaimi noticed a large, boulder-sized rock nestled under the sweet-smelling pine trees and thought this would be a good place for her to empty her stones. After a few quiet, reflective, and prayerful moments, Jaimi carefully turned her bowl over, letting the many stones she had gathered cascade down the large rock onto the surrounding soft, green grass. Jaimi then said, "Aunty Joyce, this is just like what that grandma in the story said; kinda all we need to do is turn the bowl upside down, empty our stones, and the light will grow again."

Jaimi is now in her twenties. She has graduated from high school and wishes to continue her education. She has met someone special and is expecting her first child. At last, Jaimi is living the dreams that had been locked away in the darkness of her despair.

When Jaimi and I last spoke, she told me that her bowl of light had been broken accidentally in a move. Feeling sad about what had happened, I suggested that perhaps she could make another one. Thoughtfully, Jaimi responded by saying, "No, I don't have to do that, Aunty Joyce; my bowl of light is glowing inside of me and can never be broken… It's glowing in a different way."

Part two: the bowl of light exercise

Inspired by the ancient Hawai'ian story, "The Bowl of Perfect Light," this exercise can help rebuild and enhance a sense of self-esteem and self-appreciation—the hallmarks of both inner and outer success and well-being. As we saw with Jaimi, making her own bowl of light helped her to become an active participant in her own healing process. When Jaimi decided to make her own bowl of light, she gave tangible expression to her inner changes—she created a living metaphor. The finished product wasn't shaped by anyone else's vision but her own. She also had to gather her own stones and decide when, where, and how to empty them.

Since hearing the story, I have included the making of a bowl of light in each of my workshops. In one of the highschools on Kaua'i, for example, I worked with a group of at-risk adolescents. After I had told the story, I gave each teenager a clump of fast-drying clay (about the size of a tennis ball) and

showed them how to make their own bowls of light. I explained that they would need to let them dry overnight and then decorate them over the next few days. I also asked them to go to other classrooms and become the story-tellers by recounting "The Bowl of Perfect Light" to the other students. As the teenagers shaped their bowls, they spontaneously started talking about their "stones," which were drugs, alcohol, and situations of abuse. By talking about their struggles in this way, they were already taking their first steps toward emptying the stones from their own bowls of light.

I don't know if Grandma Kaili'ohe Kame'ekua literally made her own bowl of light, but I do know that this story has inspired the birth of its tangible creation—and as with all births, growth follows.

Creating your own bowl of light

Use fast-drying, self-hardening clay (which usually comes in two-pound or five-pound boxes), acrylic paints, and brushes. Optional items include small objects gathered from nature (such as stones, sand, leaves, flowers), or special trinkets that have significant meaning in the life of your client.

Instruct your client as follows:

1. Take a piece of the clay from the larger chunk and begin to shape it into a ball. Holding the clay ball, close your eyes, take a few slow, deep breaths, and visualize your bowl.
2. When you have the image in your mind, open your eyes and begin to shape the clay into your bowl. A helpful hint is to begin by poking an indented hole into the clay ball with your thumb and slowly form the bowl from that point, turning the ball in your hand as you continue shaping from the center hole outwards.
3. When the bowl is finished, let it dry overnight, or longer if possible.
4. Next, take out the art supplies and spread them out on a table, or, if you prefer, you can work on the floor. Now take your dried bowl and again hold it in your hands, close your eyes, take a deep breath, and let the image of your bowl of light emerge in your mind's eye. Then open your eyes and begin to decorate your bowl.

I have often left my bowl unpainted, in its natural state. At other times I have painted elaborate designs.

Drawing your bowl of light

Another option is to ask the child to draw his or her own bowl of light on a blank piece of paper with the words "Bowl of Light" written across the top. The following instructions can be used:

1. Take a few deep breaths, close your eyes, and imagine seeing your own bowl of light—its shape, colors, size, and so on.
2. When you have the image, open your eyes, and draw it on the page.
3. Take your time and decorate it with all of the symbols that come to mind.

Part three: a therapeutic ritual

Identifying, gathering, and letting go of your stones

The following questions can be useful in helping your clients identify their symbolic stones—the obstacles that block the inner light and keep them from achieving their goals:

- What negative beliefs stand in the way of achieving my goals?
- What kind of life circumstances do I believe stand in the way of my success and happiness?
- What critical messages dampen my spirit? (Common examples include "I'm not good enough," "I'm stupid," "I should just work harder," "I should just do more.")

Once identified, gather one stone for each obstacle. Next, ask your clients to take their time and decide how, when, and where they want to let them go.

People sometimes say they aren't ready to let them go—they feel a need to hold onto them a bit longer. Respect each client's personal timing. Tell them that they will know when they are ready. However, if anyone feels the need to let them go, but something they can't identify seems to be getting in the way, perhaps the following questions can be helpful in clearing a path:

- What are the reasons why you hold onto the stones instead of letting them go?
- What will happen if you let them go?
- What would life be like without these obstacles?

Remember, letting go of stones doesn't mean that the incident or experience never happened, it just allows your client to reconnect to the light he or she was born with—the innate ability to appreciate the self. The important message here is to respect personal timing. I always say to my clients, "You can't yell at seeds to grow." Healing and growth come from nurturance, guidance, and respect.

References

Lee, P. J. and Willis, K. (1990) *Tales of the Night Rainbow*. Honolulu, HI: Night Rainbow Publishing (P.O. Box 10706, Honolulu).

Mills, J. C. (1999; second edition 2005) *Reconnecting to the Magic of Life*. Kaua'i, HI and Phoenix, AZ: Imaginal Press.

Conclusion

Lois Carey

This book was written with a focus on alternative methods of healing for trauma survivors. My ongoing work with sandplay was the motivating factor in my hope that such a book would be a contribution to the field of traumatology. The rationale was that if sandplay therapy was effective with this population—which had been my experience—then other expressive and creative arts modalities were equally effective. My assumptions were confirmed when I participated in a trauma conference that was held in Fishkill, New York, in March 2004 and featured Dr. Bessel van der Kolk, among others.

As I developed the ideas for this book, I asked Dr. David Crenshaw to discuss the neurobiological information in Chapter 1 that further investigated the research of Dr. van der Kolk and others and which suggests that alternative forms of treatment might be preferable to "talk therapies." Dr. Nancy Boyd Webb's contribution in Chapter 2 not only describes different forms of trauma and effective treatments with play therapy, but includes clinical examples as well.

Subsequent chapters describe additional techniques for both children and adults such as art (individual, family), music (adult), storytelling (adolescent), drama (adult), sandplay (individual Jungian, bioenergetic, and group), puppetry and video therapy (child, adolescent, or adult). While many of the chapters describe psychotherapeutic treatment of traumatized children, most of these methods can also be used with adolescents and adults and can be adapted to therapeutic work with most trauma survivors. Some chapters are more specialized, such as the chapters on music therapy, play, and sand. However, with additional study, experience, and supervision, it is possible that they can be used effectively by therapists with different orientations. The goal of all of these approaches is to access hidden, sensation-type

memories that are stored in the right brain and eventually to connect these images to the left brain, thus making the memories available for verbal recall. Healing can only be fully accomplished when the traumatized victim can finally verbalize the deep pain that negatively affects his or her daily life.

After the terrorist attacks at the World Trade Center on 11 September 2001, I was a Red Cross Volunteer in New York City with children who had been exposed directly to that horrible event. The children were dropped off in a special corner of a pier that had been set up for family assistance in obtaining housing, food, and other basic necessities. The families or other caregivers of these children spent many hours completing mounds of required paperwork. This was a very lengthy process, so a "Kids Korner" was established to accommodate the children while the adults tended to all the business details. Some of these children had lost a mother, a father, an aunt, an uncle, or someone else close to them.

Kids Korner was filled with toys and art materials of every description. Many children built Twin Towers with blocks, then had toy airplanes crash into them and knock them down. This was followed by police cars and fire engines that came to the rescue. This "play" accurately described what these children had witnessed. In the art center, numerous American flags were drawn, as well as pictures of the Twin Towers with airplanes crashing into them with bodies being ejected and falling to the ground. The children had found their own nonverbal methods to illustrate their fears, feelings, and experiences. Sandplay was not used in this site because of the chaotic nature of the setting, and because no one was available to monitor this form of expression during the many hours that this area was open.

The authors of this book are united in their belief that expressive and creative, non-traditional forms of therapy with trauma survivors can be less threatening than verbal therapy alone, and more effective in making these victims more accessible to treatment. The anecdotal examples that are provided appear to support current brain research. Additional studies are needed from clinicians who practice non-traditional forms of treatment, working together with those trained in research, to investigate further the efficacy of these approaches in the treatment of trauma.

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