

Somatic Expressions of Trauma in Experiential Play Therapy

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The authors postulate that trauma experienced during childhood effects brain functioning that is inaccessible to verbal recall. Trauma memories are observed in children's habitual and sporadic body movements. These repeated somatic expressions and affective states activate somatic disorders and traumatic traits. A correlation between trauma responses in animals to somatic expressions in children is established. The trauma effects of these unconscious, implicit memories require special strategies. Experiential Play Therapy (EPT) (Norton & Norton, 2006) has implications for accessing and alleviating these memories. In EPT, children follow patterns in their expressions of trauma experience as explained using the Nortons' 4 Ss of Trauma Expression and Healing. Utilizing these play patterns facilitates the dissipation of trauma.

Keywords: play therapy, trauma play, childhood trauma, somatic memories, experiential play therapy

Levine and Kline's (2007) statement that "Trauma is in the nervous system—not in the event" (p. 4) points out the individual nature of responses to stress. When stress is intense, severe, or prolonged, the neuronal makeup of the person is affected (Cook, Ciorciari, Varker, & Devilly, 2009), such that their stress tolerance is near its breaking point at all times, and particularly for young children who have not yet accumulated a history of security or homeostasis (Perry, Pollard, Blakely, Baker, & Vigilante, 1995; Schore, 2003). When animals and humans observe a cue that a stressor might be forthcoming, they immediately set out to protect themselves (Nijenhuis, Spinhoven, Vanderlinden, Van Dyck, & Van der Hart, 1998; Perry & Szalavitz, 2006). Because of past experiences, their neocortex is bypassed, and they move directly into brain-stem responses of fight, flight, or freeze (Perry et

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al., 1995). These behaviors appear extreme and unnecessary to more stress-tolerant individuals around them (Norton, 2007; Ogden, Minton, & Pain, 2006). These reactions and the resulting interpersonal difficulties beg the question of how to facilitate a child's movement from perpetually high internal stress toward lower internal stress with a higher tolerance to external stress. To accomplish this, it is necessary to first understand how trauma affects the neuronal makeup of children and then to search for a means of reversing the ill effects of the trauma.

Traumatic symptoms of posttraumatic stress disorder (PTSD) are truncated, that is, disrupted and uncompleted corrective responses of a trauma recovery cycle (van der Kolk, McFarlane, & Weisaeth, 1996). They are the body's instinctual and unsuccessful attempts at the healing process. Recent literature in trauma has made connections between animal responses to trauma and PTSD in humans (Levine, 1997; Nijenhuis, Vanderlinden, & Spinhoven, 1998; Ogden, Minton, & Pain, 2006; Scaer, 2001, 2007; van der Kolk, McFarlane, & Weisaeth, 1996). "Research across species concurs that the neural correlates of fear conditioning include involvement of the amygdala during all stages of fear learning" (Fanselow & Ponnusamy, 2008, pp. 38–39). Nijenhuis et al. (1998) found high correlations in subjects with dissociative disorders having somatoform disorders that parallel defensive responses demonstrated in animals under attack that were not found in the control group. Fanselow and Ponnusamy have made a strong argument of using Pavlovian fear conditioned responses demonstrated in animals as explanation for freezing, startle, and fear-induced analgesia observed in humans. Although there is very little research on animal behaviors and their parallel in children, Perry et al. (1995) have demonstrated drastic, negative effects on the brain of children who have experienced abuse and neglect.

When animals are not able to complete the trauma cycle, inescapable shock manifests as learned helplessness, which parallels dissociation and other PTSD symptoms in humans. Using Experiential Play Therapy (EPT) and Nortons' 4 Ss of Traumatic Expression and Healing, traumatic symptoms can be identified and treated by following and encouraging the healing sequence of the phases of Sensation, Soma, Surge, and Soothe, thus helping the child correct instinctual responses of trauma through play and somatic reflections (Norton, 2008).

ANIMAL STAGES OF DEFENSIVE RESPONSE

Ogden, Minton, & Pain (2006) draw parallels between adults with PTSD and animal defensive responses in seven stages: (a) marked change in arousal, (b) heightened orientation response, (c) attachment and social engagement, (d) mobilizing defensive strategies, (e) immobilizing defensive strategies, (f) recuperation, and (g) integration. Each defensive response is typically definitive, primitive, inflexible, and hierarchal because the preceding defense in the hierarchy must be completed before the next one can be initiated (Ogden, Minton, & Pain, 2006). The more primitive a defense, the more energy it contains (Perry, 1994). Repeated use of these defenses without completion either overactivates or inhibits the neurology, short-circuiting the *recuperation* and *integration* stages (Ogden, Minton, & Pain, 2006). Trauma patterns the neurology of the vagus nerve to be locked in a constant state of hyperarousal or hypoarousal (Scaer, 2005).

When danger is present, the prey animal suspends its normal activities and enters a state of *increased arousal* (Ogden, Minton, & Pain, 2006). Senses are directed to a narrow spectrum of input, only hyper-focusing on the source of danger. In this initial freeze, the animal goes into a hyper-sensory state and motor activities are frozen. During the freeze state, indigenous opiates are released causing a reduction of fear, pain, and panic and inhibits the production of sound and vocalizations and soothing behavior (Nijenhuis, Vanderlinden, & Spinhoven, 1998; van der Kolk, McFarlane, & Weisaeth, 1996). Because vocalization is especially dangerous at this point, the Brocas area of the brain is incapacitated by the increased opiates, reducing the possibility of inadvertent, fearful vocalizations that would attract the predator.

The second reaction in the defense response is *heightened orientation*. In this stage, the animal searches for an escape. Younger animals will look for their mothers. If an escape is not available, the animal will remain in a frozen state; if this is maintained for extended periods of time, the animal will stay in this hypo-aroused state even when the predator is no longer a threat (Nijenhuis, Vanderlinden, & Spinhoven, 1998; van der Kolk, McFarlane, & Weisaeth, 1996). Van der Kolk, McFarlane, & Weisaeth (1996) call the sustained effects of this immobility incapable shock.

The third defensive response is *attachment and social engagement*. Two behaviors are associated with social engagement: disarming the predator and crying out for help. In social engagement, animals will often try to disarm the attack through friendly, appeasing, or submissive gestures. In *attachment*, baby animals call out to their mothers and adult animals cry out to others at the moment of an attack. "Flight sometimes involves not only a running away from danger, but also a running toward a person or place that can provide safety (a basic premise of attachment behavior)" (Ogden, Minton, & Pain, 2006, p. 91). This cry or scream is established in the ventral vagal nerve of the brain stem, is a primordial scream for mother, and is the involuntary scream we often make when someone jumps out at us in the dark. For weaker or smaller animals, this is often suppressed. Freezing is the most common response, even when an escape is available (Nijenhuis, Vanderlinden, & Spinhoven, 1998; Ogden, Minton, & Pain, 2006).

When forced, the prey animal will fight and engage in the stage of *mobilization of defenses*. The animal still has analgesia (tactile numbing) caused by indigenous opiates so that wounds can be ignored and soothing behavior repressed (Ogden, Minton, & Pain, 2006). When flight or fight is successful, the animal will initiate recovery behavior when it is safe. These behaviors include soothing, sleeping, and playing.

The *immobilization of defensive strategies* is initiated when escape is not possible. It is called "type two freezing or preparation for a merciful death" (van der Kolk, McFarlane, & Weisaeth, 1996, p. 94). The animal does not vocalize because of a "speechless terror" (van der Kolk, McFarlane, & Weisaeth, 1996, p. 193). This action is activated in the brain stem, thus shutting down all activities of higher brain functioning including the emotions activated in the limbic system (Siegel, 1999). This serves two purposes. First, it may disengage the predator, making it look as if the prey animal was dead, thus stopping the attack. Second, the prey animal does not have to suffer the pain and horror of its own death by instinctively activating a trance state (van der Kolk, McFarlane, & Weisaeth, 1996).

When filmed and played back in slow motion, this state can be observed as the last action taken by an animal before the predator connects (Scaer, 2001). When the animal is attacked and manages to escape after it has gone into the trance state of feigned death, it will engage in violent seizure behavior, thus discharging the traumatic energy (Levine, 1997). Discharge of this traumatic energy is crucial for the continued survival of the animal (van der Kolk, McFarlane, & Weisaeth, 1996).

In the *recuperation stage*, the animal or its mother will lick injured areas and the animal will engage in extended sleep (Nijenhuis, Vanderlinden, & Spinhoven, 1998). It is suspected that the extended sleep of children after recuperation is a correction of REM sleep that is disrupted in abused children (Norton, 2007; Pynoos, 1990). Recuperation most likely involves limbic activities of emotional expression and regulation.

In the *integration stage*, the animal returns to normal activities. In young animals this would include attachment behaviors and play. Humans, like animals, demonstrate integration when they can return to activities of daily living. Truncated traumatic energy prevents the complete return to daily activities by maintaining a constant state of hypervigilance and trauma reenactment as seen in PTSD (Ogden, Minton, & Pain, 2006).

INESCAPABLE SHOCK AND LEARNED HELPLESSNESS

Interruption of the attack recovery cycle leads to inescapable shock and learned helplessness (Seligman, 1975; van der Kolk, McFarlane, & Weisaeth, 1996). An animal can remain stuck in the defensive strategy of mobilizing defenses. Animals that are exposed to persistent threat and are not allowed to escape will be conditioned to freeze and will fail to use available escape behavior when presented with threat in subsequent trials (Scaer, 2001). Animals exposed to prolonged threat have limited resiliency when exposed to later threats (Ginsberg, 1975). The consensus of the literature is that if traumatic energy is not released, it is remembered in the behavior and the body of the victim (Levine, 1997; Ogden, Minton, & Pain, 2006; Scaer, 2001, 2007; van der Kolk, Greenberg, Boyd, & Krystal, 1985; van der Kolk, McFarlane, & Weisaeth, 1996). As far back as 1893, Pierre Janet had observed motor reenactment of original trauma by patients (Janet, 1901). Ogden, Minton, & Pain (2006) have observed the same motor memory in adults with PTSD. When remembering the attack, these adults will make subtle kicking, running, fighting, and/or pushing-away movements. Lynch (2000) made the same observations in a severely abused 11-year-old girl. Gaensbauer (2002, 2004) has documented trauma reenactment in toddlers from trauma experienced as infants. Several other authors have documented behavioral memory where the trauma happened between birth and one month, often before these children developed language and explicit memory (Azarian, Lipsott, Miller, & Skriptchenko-Gregorian, 1999; Burgess, Hartman, & Baker, 1995; Gaensbauer, 1995; Hewitt, 1991, 1994; Howe, Courage, & Peterson, 1996). Terr (1988) found verbal and behavioral memories of children traumatized under the age of five. Sugar (1992) demonstrated that children as young as 19 months could give a verbal account of trauma.

CHILDREN'S STAGES OF DEFENSIVE RESPONSE

The traumatic symptoms of PTSD are results of truncated attack and escape behavior akin to learned helplessness observed in animals (van der Kolk, McFarlane, & Weisaeth, 1996). Symptoms tell the traumatic story and are expressions of energy that are stuck in defensive strategies (van der Kolk, McFarlane, & Weisaeth, 1996). The push to discharge this truncated energy leads the child to reenact the trauma, thereby giving the child multiple opportunities to discharge defensive energy. For the purposes of this paper, the focus will be on trauma reenactment as it is observed in children's play therapy sessions as compared to animal defense responses. There are basically three clusters of defensive behavior: (a) preattack or hypervigilance, (b) mobilizing defensive strategies of fight/flight, and (c) immobilizing defensive strategies or hypo-arousal.

When the behaviors of *heightened arousal*, *attachment*, and *social engagement* become truncated, these preattack behaviors in an animal's *orientation* become pathological symptoms when they occur in humans. Hyper-arousal, hypervigilance, hyper-focus, and exaggerated startle response are all preattack behaviors stuck in the vagus nerve of the brain. Also associated with this stage are motor freezes and disrupted vocalization. Perry and Szalavitz (2006) describe this in children as "the 'freezing' response that the body makes when stressed—sudden immobility, like a deer caught in the headlights When it occurs, the child literally cannot respond to commands" (p. 51).

In play sessions, hypervigilance is often demonstrated by oversensitivity to noises outside of the play room, inability to engage in fantasy play, being overly frightened by what the therapist says to the parent, persistent questioning concerning trust and safety, and taking a long time to trust the therapist.

In heightened orientation behavior, the child will start to play but, as they start having sensory and emotional memories of the attack, the child will move away from that play scene to avoid the memories, as if searching for an escape from the mounting anxiety. In this derailment, the child will engage in another play theme only to approach the memory of the trauma and retreat once again. There is a restricted expression of emotion and seemingly all-around avoidance. It is as if the child is searching for a way out of an anticipated attack due to unconscious memories and mounting anxiety.

Attachment and social engagement are often played out with failed communication. The child will pick up a toy phone or other communication device and attempt to contact a protective adult. In traumatic expressions of this nature, the child will make comments like "No one is there," or "No one answered," or the child will despondently drop the phone. Ogden, Minton, & Pain (2006) have observed that "adults turn to their cell phones in order to find their primary attachment relationships when they feel under threat" (p. 90). Another expression of this occurs when parentified behavior is displayed. The child will demonstrate social engagement by being overly concerned with taking care of the therapist. This parentified behavior is an attachment strategy to take care of the adult and to disengage the adult from his anger. It is plausible that this instinctive reflex is, in part, the cause of victimized children identifying with the abuser because, in doing so, the intensity of the attack could be lessened. It may also contribute to an

overwhelming sense of responsibility and guilt. If unable to appease the perpetrator, the child feels like he has failed.

It is in the *mobilizing defensive strategies* of fight/flight behaviors that attack/trauma reenactment is likely to occur. Attack reenactment symptoms are described mostly in the *DSM-IV-TR* (American Psychiatric Association, 2000) Criteria B for PTSD and replicate the escape attempts of animals. The child remains in a constant state of being attacked. Krystal (as cited in Ogden, Minton, & Pain, 2006) writes, "We would say that traumatized individuals get stuck in the particular repetitive action tendencies of defense that were evoked at the time of the original trauma and are evoked again and again by environmental clues reminiscent of the trauma" (p. 86). "In young children, repetitive play may occur in which themes or aspects of the trauma are expressed . . . trauma specific reenactment may occur." (*DSM-IV-TR*, 2000, p. 468). Terr (1983) has also identified repetitive play as a traumatic response.

Somatic reenactment is attributable to "ready-made 'motor tapes' . . . that, when switched on, produce well defined and coordinated movements; [like] the escape response . . . Fixed action patterns comprise a variety of simultaneous and sequential movements" (Ogden, Minton, & Pain, 2006, p. 133). They also state, "These incomplete actions of defense subsequently may manifest as chronic symptoms" (Ogden, Minton, & Pain, 2006, p. 21). Subtler expressions of this can be identified by close observation of children's play. Children in this stage will show startle behaviors, in several ways. They may make high-pitched noises; they may have a rapid increase in energy, a rapid increase in anxiety (Norton, 2007) or spontaneous jerks and rapid movements. Sensory reenactment occurs frequently, mostly in actions that show the pain (Norton & Norton, 2002). In this phase, the child's body starts reexperiencing the sensations of the attack. They will unconsciously demonstrate attempts at soothing traumatized areas of the body and protecting them. For instance, a child who has been sodomized will often brush their hand across their buttocks. Nijenhuis et al. (1998) state that animals will continue to soothe wounded areas long after healing. Children will also demonstrate the pain by screaming, grunting, moaning, pointing out "owies," by accidentally hurting themselves, or metaphorically demonstrating on the therapist what has been done to them. For instance, a child who has been spanked with a belt will swing the broad side of a sword at the therapist's backside while defensively placing his hands over his buttocks and lifting his legs, just as s/he did in the original spanking. Motor reenactment is frequent and repetitive in children's traumatic play.

The *DSM-IV-TR* (American Psychiatric Association, 2000) Criteria A describes affective reenactment as follows: "The person's response may involve intense fear, helplessness, or horror. In young children, this may be expressed as disorganized or agitated behavior" (p. 467). In the play session, this is demonstrated by anxiety, freezing, and expressions of anger, fear, or sadness. The child's play can be disorganized or the child may show reluctance to play. Often, children will engage in play that attempts to modulate unwanted emotions. They might avoid personalizing the content by playing symbolically or by creating emotional distance with toys or action figures (Ferriegel, 2007; Norton & Norton, 2002). Derailment and dissociation are frequently used to regulate emotion. Children overwhelmed with emotion might end the session prematurely, interrupt the session, or be reluctant to reenter the play room after a difficult session.

Motor reenactment in trauma is made up of protective movement and submissive action (Janet, 1901). In animals, as with children, their submissive actions are sometimes taken to prevent increase in the attack of the predator (van der Kolk, McFarlane, & Weisaeth, 1996). Protective behaviors can be expressed by wiping or brushing traumatized areas with the hand or placing the hands, arms, head, and/or legs in a protective posture. In subtler expressions, this can present as twitches in the face, arms, buttocks, neck, shoulders, legs, or other traumatized areas. Children who have been slapped or hit in the face will flinch when an adult reaches toward a shoulder. The child may display submissive behavior by taking certain postures that were taken during the attack. “The pattern of defensive and protective movement at the time of the traumatic event is stored in procedural memory for the purpose of adaptation to the future related threat, and incorporated in regional neuromuscular detail into the kindled cycle of trauma” (Scaer, 2007, p. 23).

Dissociation parallels inescapable shock in animal studies and is considered by multiple authors as the main predictor of developing PTSD (Nijenhuis, Vanderlinden, & Spinhoven, 1998; Ogden, Minton, & Pain, 2006; van der Kolk, McFarlane, & Weisaeth, 1996). Dissociation is the instinctive human parallel behavior of animals preparing for death and is a sustained response to attack (van der Kolk, McFarlane, & Weisaeth, 1996). It is expressed in less intense forms such as hypo-arousal with symptoms like emotional numbing, motor freezing, physical numbing, amnesia, loss of concentration, distortion of time, inhibition of vocalization, and loss of explicit memory. Perry and Svalavitz (2006) describe this behavior in children as follows:

During dissociation, the brain prepares the body for injury. Blood is pumped away from the limbs and the heart rate slows to reduce blood loss from wounds. A flood of endogenous opioids—the brain’s natural heroin-like substances—is released, killing pain, producing calm and a sense of psychological distance from what is happening (p. 50).

In children’s play, this is expressed somatically with sudden stops in the play accompanied by intense gazing with a glassy look to the child’s eyes. The child literally looks frozen.

Dissociation happens on a continuum (Scaer, 2005). In children’s play, it often precedes or is in conjunction with derailment. References to dissociating in play will have metaphoric themes of being dead or killing the therapist when the therapist is placed in the victim role: ghost or zombie; statements of “going away” or disappearing; escaping in vehicles (especially flying vehicles like planes, rockets, or balloons); going to far-off exotic places like Tasmania; teleporting and disappearing; and third-person depersonalization roles like that of a narrator (Norton & Norton, 2002). When children play out these themes, they are enacting that which was dissociated during the attack.

TRAUMA RECOVERY IN EXPERIENTIAL PLAY THERAPY

Van der Kolk, McFarlane, & Weisaeth (1996) state, “Treatment needs to address the twin issues of helping patients (1) regain a sense of safety in their bodies and (2) complete the unfinished past” (p. 17).

Children who are traumatized will reenact the trauma experience during play (Schore, 2003; van der Kolk, McFarlane, & Weisaeth, 1996). The experiential play therapist has the responsibility to assist the child in the process of releasing the truncated defensive responses that occurred during the trauma event. Such functions as relational interactions, social/emotional perception, sensations in the body, and bodily functions are identified disruptions. Addressing these activities is crucial in the recovery from the trauma impact (Schore, 2003). These memories can present in several forms (van der Kolk, McFarlane, & Weisaeth, 1996) and occur during play therapy sessions. EPT also focuses on the sensorimotor presentation of the child during play therapy. This includes their proprioceptive process, motoric reenactments, and metaphorical meanings symbolic of the trauma experience. These considerations are not usually the focal reference for most forms of play therapy. The EPT therapist responds in like manner to the sensory experiences of the child, thereby allowing the child to enhance the physical or bodily active expressions. Being alert to subtle expressions allows the therapist to note the trauma expressions that are active in the total experience of the child at that moment. Norton (2007) identified a sequential process that children spontaneously employ in EPT to confront the feelings and bodily sensations they experience with memories of the original attack or assault. This process is accessible in fantasy play through the use of metaphorical expression. "To the traumatized child, fantasy play is disguised reality" (Norton, 2007, p. 9). This process seldom emerges in a linear fashion. The process is more adequately described as a looping pattern that is reexperienced several times with relief occurring each time the child reaches the fourth phase. These phases have identifiable characteristics and merge from one phase to the next. Children in EPT use several levels of experience to reflect the trauma energy consuming their body and awareness.

NORTONS' 4 Ss OF TRAUMA EXPRESSION AND HEALING IN EPT

It is difficult to find studies that focus on the physiological and neurological effects of trauma on young children's behavioral and functional capacities. A plethora of studies (Green, Flowe-Valencia, Rosenblum, & Tail, 2001; Grover, Carpenter, Gagne, Mello, & Tyrka, 2007; Spitzer et al., 2009; Waldinger, Schulz, Barsky, & Ahern, 2006) from an adult perspective show a high correlation between trauma in childhood and later physiological and psychological dysfunction. However, these studies are retrospective in nature and do not consider the immediate trauma process expressed from the young child's experiences. These studies address the effects of trauma on adult lives but exclude the immediate effects endured by the young child to survive using primitive responses to trauma. Anatomical research (MacLean, 1990) shows that the neocortical area of the brain may expand in size for different mammals. However, the size of these limbic systems remains significantly consistent with human brains. The brains of all primates are allometrically scaled versions of basically the same design for human limbic functioning (Rilling, 2006) and respond in a comparable fashion (Gilmer & McKenney, 2003), which is the premise of this article. In children, the limbic system is developed so that the child responds to cues of danger when the neocortex is not yet developed

enough to determine whether the cue represents actual danger or not. Therefore, primate and other mammals' functioning relate more directly to the physiological and neurological trauma functioning style expressed by children. Animal studies, as provided in this article, give considerable validation to the internal functioning that represents trauma activity in children. If play therapists could identify these specific reactions expressed during play therapy sessions, the possibility exists for preventing somatically based childhood trauma from manifesting as serious adult illnesses.

Children express symptoms of trauma in a personalized style in play therapy. This is established within the framework of a supportive and secure relationship (Norton, 2008) that allows the child to move into aspects of their trauma experience totally accepted by the experiential play therapist. During play therapy, as the child confronts the conscious memories of the trauma, activation systems (van der Hart, Nijenhuis, & Steele, 2006) and unconscious processes create deeper reactions in the child. The child begins a play process that confronts the trauma experience, gives the child the opportunity to begin developing new neurological sequences, and provides integration of the trauma leading to reduced symptomology (Levine, 2007; Norton & Norton, 2006). The sequence in which the child confronts their trauma and initiates overcoming the helplessness felt during the original event is identified as the Nortons' 4 Ss: Sensory, Soma, Surge, and Soothe (Norton & Norton, 2006).

Van der Kolk, McFarlane, & Weisaeth (1996, p. 290) describe investigations that found four basic levels of memory processing of trauma: somatic, behavioral, visual, and verbal. As the child plays, memories of the trauma experience can emerge into the play by means of intrusive memories, startle responses, flashbacks, or hypervigilance triggered in the immediate environment. Other triggers can be as subtle as anniversary syndrome, seasonal memories, or olfactory memories. The child may have avoided experiencing any sensations associated with the trauma in daily living. Some children may avoid physical exercise because the rapid heartbeat is a reminder of the trauma sensation. When these sources of arousal are experienced, the child begins a sequence that is observable as the play continues. The child's body, awareness, attitude, and behavior become oriented to the threat that represents the trauma. This activates a process to ward off the sensations and confront the trauma experience. This leads to the first phase of trauma expression by a child, that is, the sensory phase.

The Sensory Phase

When a traumatic reaction is activated, dissociated sensory memories are reexperienced (van der Kolk, McFarlane, & Weisaeth, 1996). These memories can be visual, auditory, tactile, olfactory, gustatory, or motor responses, but most often they are a fragmented combination of these. This activation can occur in a matter of seconds or minutes. The child may dabble in the sand to experience the tactile sensations, indicate hypervigilance through the binoculars, or rub some place on their body that indicates somatic vulnerability. This can be accompanied by a dissociative reaction, motoric freeze, or a preoccupation with a toy as if the toy represented the threat. The therapist does not focus on language responses that distract from sensory awareness. Instead, the exper-

rential play therapist reflects guttural noises, grunts, groans, growling, or other primitive sounds that amplify and track the child's orienting movements or through acting the roles given by the child. This provides the child with validation of what s/he is experiencing in the moment. A major concept of EPT is the statement, "Trauma does not speak language" (Norton, 2007, p. 4). This validation of the child's sensations moves the reaction to the soma phase of the trauma expression.

The Soma Phase

The building of trauma energy that is being experienced in the child's body represents the soma phase. In this phase, children's bodies start showing somatic memories of the attack. The soma phase refers to the body's response to the intensity of the action system described by van der Hart, Nijenhuis, & Steele (2006), or "trauma energy," that is escalating within the body. The child's body has been reactivated around the trauma experience. The soma response indicates the body is orienting to the trauma event or experience. Van der Hart and Op den Velde (1991) make the point that "a traumatic memory cannot be adequately processed if its affective and sensory-motor elements remain isolated from the rest of the memory" (p. 83). Reactions exhibited at this phase include swelling of areas of the body trunk such as swelling of the chest, protection of the stomach or buttock, and arms in the air to protect the face and head. Other observable reactions are loss of motoric capacity in which the child loses degrees of coordination. Often a child becomes agitated, causing stumbling movements or awkwardly bumping into objects and complaining of hurts. The bodies of some children become rigid with legs stiff and straight and so that they walk like a "wooden soldier." This belief of trauma reenactment in motor movements is supported by Scaer (2001) and Janet (1901). These somatic reactions are indicative of the constriction or immobility response that occurred at the time of the original trauma. Children assume the position they endured in the trauma event (Levine, 2007). This is where the unconscious hand movements of protection or body positioning are symbolic of the trauma that occurred. Not uncommon are screams, screeches, or guttural sounds associated with the intensity and awareness of the threat orientation. This parallels animal reenactment of coming out of the freeze (Levine, 2007) and appears as if the child is showing us the recovery tremors of trauma release in slow motion. The soma response may last for a few minutes or may be repeated for as long as 20 minutes. The need to transmit this compressed energy leads to the next phase—to purge the trauma energy from the body. This is called the surge.

The Surge Phase

The surge phase is the process of discharging the trauma energy through bodily expression. The surge or discharge is the action of the body to orient and complete the behaviors or responses that were thwarted in the original traumatic event. Some

children freeze and are immobilized at the time of the trauma when the child was powerless to exhibit action. The truncated trauma response is now reactivated. The child can thus exhibit the response the body desired to perform but was unable to execute because of danger, threat, and the need for self-preservation. With no power at the moment of trauma, the child was unable to respond effectively. The child lost all sense of power, control, and dignity during the event. This phase of trauma expression is characterized with an intense discharge of the trauma energy that has been contained or restricted in the body since the trauma event occurred. The child's body becomes their source of discharge with anger and aggression surging into their play expressions.

In EPT, the child is given the opportunity to now act out the response that was never allowed in the trauma situation. The surge is often aggressive; for example, it may be fighting the perpetrator, running to escape the threat, or jumping, and thrashing to fight off the fear object. During this expression, children may hit or throw the toy object that represents the fear source. Children playing with clay will smash the created object or squish it in a pressured style that destroys its identified meaning. Some children will kick toys or throw a ball with intense force to symbolize the distancing and fight response that was inhibited at the time of the trauma. Boys will often shoot guns at an identified object that represents their perpetrator. Girls, who have the right to express their rage as directly as boys, tend to hide the fear object or dominate it in a more relational style. The important point is the discharge of the trauma experience from the body. The child may appear to be out of control; however, it takes an out-of-control response to dissipate an out-of-control trauma event. Vocalization, including yelling and screaming, becomes integrated into their response. "The more children display guttural, primitive sounds in their play, the more meaning the content has to the child and the closer to the core issue" (Norton & Norton, 2002, p. 127). The child has to equalize the tremendous restricted trauma energy that has been contained in their ineffectual survival response. Increasingly, the experiential play therapist is placed in the role of abuser while the child fights off the attacker. Through empowered play, the child locks up the perpetrator, thereby restraining or containing the fear symbol. This encounter is metaphorical in nature; however, it is real in the neurological system. The surge response may occur over one or a number of sessions in the initial expressions by the child. Most children must sequence through the sensory, soma, and surge phases several times before integration of the trauma response will occur. Integration happens in the soothe phase of trauma expression.

The Soothe Phase

During the soothe phase, the child once again has the capacity to regain some form of self-regulation after discharge of the trauma energy. Once the child has had the opportunity to purge a significant proportion of their trauma energy, he can experience a soothing response that represents the release of the trauma response in the body. After several intense discharges in play, the child transitions into a soothe response. This represents the beginning of healing. At this moment, the child begins to regain the sense of self that was lost during the trauma event. This

is the integrative process that returns to the child their sense of dignity and security, which indicates they have regained control of their world, appropriate to age and stage of development.

After all the rage and aggressive play expression, the response that next occurs is a calm, soothing style of play. Initially, the soothe response is short and limited. For example, a child may strum the guitar in a pensive manner and focus their perceptions internally to “feel” the music. The play therapist listens but does not respond to this personalized process until the child breaks the trance. The therapist can validate the joy that was experienced in that brief moment. Many children like to draw flowers or nature scenes as their metaphorical form of soothing. Other forms of the soothe response may be expressed in constructing something or indicating the significance of a special relationship.

Each time the child moves through the sequence of sensory, soma, and surge and arrives at soothe, the intensity of their trauma energy begins to dissipate. The surge intensity decreases as the soothe response increases. The child integrates their sense of well-being in relation to their environment and the world. The child’s struggle to survive changes to a feeling of security. A final “S” could be that of reclaiming of “Self” (Ferriegel, 2007). This eventually leads to more developmentally appropriate styles of relational play. When survival is no longer a question, the child can orient to relationships that foster their developmental and social needs.

Some children who were severely traumatized may go through this process several times before the sense of ownership of their body is regained. Most children who have been traumatized go through the first three phases of the trauma expression but cannot reach the soothe phase in daily living without the therapeutic relationship as the catalyst that facilitates this process. Many children who have been traumatized experience the first two phases of the trauma expression and go on to discharge at school. There, they are punished for inappropriate behavior, an inappropriate attempt at discharge that affected other children or property. Unfortunately, school is not the correct setting in which to facilitate their expression from release to soothing. In these cases, secondary trauma is created that simply revictimizes the child struggling to cope in a world perceived as threatening.

THERAPEUTIC ATTUNEMENT IN EPT

In using somatic language, the treatment of traumatized children can be shortened through the act of attuned somatic reflections (Schoe, 2003,) by the experiential play therapist (Norton, 2007). During play, therapists should be alert to a child’s bodily expressions as they work with children of trauma. By responding to play through playing, the experiential play therapist helps bring into focus the organizing principal of play, allowing for corrective social engagement and fulfilling relationships.

CONCLUSION

Beginning with Harlow (1958), extrapolating from animal behaviors to human behavior has been common practice. In addition, experience has shown that the

phases of children's recovery parallel the recovery cycles of animals. It follows, logically, that children, who are closer to the occurrence of their trauma, will instinctively move into the same pattern of recovery as other mammals. Gaskell (2008) identifies the play therapy of trauma as needing to address the lower brain functioning through movement and sensory activities. Van der Kolk (2006) also suggest the more nontraditional forms of therapy that focus on body and sensory awareness, body-mind centering, and sensory experiences. By identifying the instinctively universal language of trauma in the body and by utilizing somatic attunement and reflections, children of sexual and physical abuse can access their implicit memories of traumatic events in order to heal. Key (2009), through brain imaging studies, has demonstrated that psychotherapy alters brain structure and function. His conclusion is that early intervention through psychotherapy has important implications in the treatment of children and the new neuronal connections that are formed. Thus, their habituated ineffective reactions to perceived threats gradually change to more adaptive responses. EPT supports this sensory motor recovery process in young children. It is the belief of the authors that the relationship with the therapist replicates the social engagement necessary for the completion of the trauma cycle.

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