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Treating Traumatized Children: Somatic Memories and Play Therapy

Shira Spiel, M.A., Karen Lombardi, Ph.D., and Laura DeRubeis-Byrne, M.A.

ABSTRACT

Drawing on psychoanalytic theories of infant development and children's preverbal memories, this article explores the somatic memories in young children who experienced trauma and the level interventions necessary to facilitate the transformation of these traumas from concrete to symbolic representations. The clinical case of a 3-year-old boy who experienced hospitalizations and multiple surgeries prior to the age of 2 is used to illustrate the efficacy of play therapy for traumatized children. We argue that children do remember traumas from their infancy, and interventions geared toward re-enacting the traumas through play are necessary to help these children symbolize their experiences and alleviate their trauma symptoms.

Introduction

The 1973 publication of *The Competent Infant* (Shore, Smith, & Murphy) marked a watershed in our appreciation of the capacities of infants and young children. The mental lives of infants were no longer thought to be "one great blooming, buzzing confusion" (James, 1890), as data began to emerge regarding babies' capacities to perceive, discriminate, and make meaning through experiences in various sensory modalities. Dan Stern's (1985) important work, from a relational lens, on the development of subjectivity in infancy and early childhood contributed to our recognition that babies, through their various sensoria, are, from birth, continuously experiencing and processing information from their environment. Sensorimotor experiences at what Stern (1985) describes as the emergent, core, and intersubjective levels of the self, all occurring developmentally before the emergence of verbal language, can lead to memory traces that remain encoded within us. At the same time, old ideas die hard. As mothers, we still hear those who say of our smiling 6-week-old babies as we gaze into their faces, "It's just gas," despite evidence babies are hard-wired to prefer facial configurations and are actually better than adults at making visual discriminations of faces (Pascalis, de Huan, & Nelson, 2002). As psychologists, we still hear parents insist their children have

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no sense of their relational conflicts because "we never fight in front of them" or "we've never spoken of that." In the last few decades, we have become increasingly aware of the degree to which, historically, we have misunderstood and underrated the psyches of babies and young children. We are now less likely to dismiss the subjectivity of young children and their capacity to register, on a core or somatic or bodily level, their experiences, to remember and make meaning of them.

Episodic memory in infancy and early childhood

It was my (KL's) experience as a mother that underscored the salience of episodic memory in babies and young children. When my daughter Chloe was 20 months old, we were on our annual family visit to her grandparents in Eugene, Oregon. We went with friends to a rather large indoor food market, and I left Chloe sitting at a table with my friends while I went to get lunch for her. When I returned, I was told she fell off her chair and cried a bit, but was unharmed. On our trip the following year, when we pulled into the parking lot of the same food market, Chloe announced, "I fell down!" I was astonished she remembered and even more astonished to be reminded of my absence — I was not present for her fall and wondered if she needed me to remember to keep her in mind.

Most experimental evidence claims episodic memory begins from around the age of 3 or 4. The traditional developmental perspective asserts that autobiographical memory, a subset of episodic memory, is lacking until age 6 or 7 (Bauer, 2015). Chloe's vignette offers evidence that biographical episodic memory exists much earlier than that; Stern's work on the observed infant argues similarly, stating episodic memories in infancy are experienced and retained through interpersonal interactions.

Preverbal episodic memory, recognition, and the mark of trauma

There is considerable clinical evidence to suggest trauma experienced on a somatic level in infancy and early childhood is retained in episodic memory on a nonverbal or preverbal level, and that these experiences remain unprocessed and held within the body (e.g., van der Kolk, 2014). The trauma may be acted out until, or unless, it can be modified through recognition. In their work with traumatized infants and young children, Novick and Novick (1991) speak of the sequelae of trauma in terms of sadomasochism, the beating fantasy, and externalization. They state "the classical view is that the failure of omnipotence forces the child to turn to reality. In our view, it is the failure of reality that forces the child to turn to omnipotent solutions" (p. 320). An omnipotent sadomasochistic system of self-regulation may take over, turning the experience of helplessness into an omnipotent defense. The particular focus of this article is on the sequelae of bodily trauma experienced as an attack and the ways in which they make themselves known on a subjective level. Such experiences call for therapeutic interventions that meet the child on the level of bodily or somatic experiences; such recognition allows for a shift to meaning making on a more symbolic level.

In *The Work of Psychic Figurability*, Botella and Botella (2005) argue for the presence of an intuition that has never been developed, traces of which exist in ghostly or shadowed forms. There is an absence of representation of what is, in some form, already experienced. For our purposes, they discuss the case of Thomas, a 4-year-old boy who had undergone numerous hospitalizations and surgical interventions from birth to age 20 months. Thomas was delayed in his development, speaking only a few words when he entered treatment. The Botellas report the parents thought Thomas was autistic; they themselves did not agree, stating Thomas had never lost his appetite for the object. They describe him in sessions as passionately breathing in a pot of glue, of lying down in the rays of sun that would come through the window, and of repeatedly making noises, especially going "grrr…grrr!"

After failed although probably somewhat accurate verbal attempts to tie Thomas's activities to the smell, the light, and the noise of his hospitalized experiences ("when you were in the hospital, where the smell was very strong and the light was very bright, it was difficult to breathe… it was as if everything was going grrr… grrr!" [p. 31]), the analyst hit on entering Thomas's nightmarish trauma with him, saying, "grrr… grrr… are you afraid of the wolf?" while at the same time enacting the biting and clawing

viciousness of the wolf. This intervention brought Thomas to life; he became the wolf, growling and playfully trying to frighten everyone in the clinic, yelling out "grrr…grrr… the wolf!"

The significance of Thomas's vignette is the necessity of discovering the level of intervention with the child that corresponds to his or her experiences. Botella and Botella (2005) say their first interpretation failed to meet the level of psychic representations in the child. Alvarez (1992) goes further and is the most instructive when she discusses the importance of not puncturing the child's fantasies of mastery. Accordingly, we view the earlier interpretation as placing the child back into his feelings of passivity and helplessness in the face of trauma, whereas the playing out of the attacking wolf creates a space where the child can re-experience the trauma on the level of play and identification. Encountering the wolf allowed for the possibility of playing out the terror from both sides. The wolf might get you, but there is a possibility in play that you might be as strong as the wolf, that you might take over that power for yourself, and that in finding and building your own strength you can face the traumas of the past and no longer be crippled by them.

Coates (2016) discusses the case of Betsy, a highly verbal child who was attacked and stabbed in the stomach at 10 months old while in the park with her nanny. She underwent a life-saving eight-hour surgery. Betsy's parents recalled no trauma symptoms after her hospitalization. However, when she was 3 years old she was leaning against the sink in her kitchen and announced, "my line hurts," referring to her scar, and went on to make a slashing gesture, saying, "it was a very bad day" (Coates, p. 758). Coates treated Betsy when she was almost 5 and describes the work of transforming her somatic memory of the assault to a more elaborated autobiographical memory. It is notable that although her parents had spoken often to Betsy of her surgery and her scar, they had never spoken to her of the circumstances of the attack. The medical aspects of the trauma were available and processed to some degree; the "bad man" who perpetrated the vicious attack remained unaddressed, a secret part of the story Betsy already knew on the level of somatic memory. Coates sees the parents' attempt to protect Betsy from the reality of her experience as not only unhelpful but also as having the effect of suppressing Betsy's natural curiosity. Betsy received the unspoken message that her trauma was traumatic to her parents, and she protected them by not asking questions about the attack. Therapy was needed to allow the unspoken message to emerge.

From somatic experience to representation: A clinical illustration

The following case is of SS's treatment of a 3-year-old boy, which demonstrates a capacity for the development of symbolic play in the face of preverbal trauma.

Darren is a 3-year-old Latino-American boy who lived with his mother, father, three older siblings, and his younger brother, who was born about halfway through the treatment. Darren was born prematurely, weighing approximately three pounds at birth. His mother indicated he was a mellow baby, easy to soothe, ate well, and reached his developmental milestones at appropriate ages until he developed a serious medical condition. At about 15 months old, he developed an acute severe medical condition that affected his brain. Following this acute incident, he was placed in a medically induced coma for about three weeks, in which he was intubated and placed on a feeding tube. When he awoke, he needed a feeding/swallowing specialist to relearn to eat solid foods and needed physical therapy to regain gross muscle control. During his medically induced coma, and after his discharge when he was an outpatient, he underwent several brain operations over the course of a few months. After this incident, he was more temperamental and difficult to soothe.

Darren attended a therapeutic nursery school in the New York City area with a special education classroom. Darren was referred to the therapeutic nursery school for global delays in speech, play skills, and gross and fine motor development. In addition to special education, Darren received school-based psychotherapy (play therapy), speech and language, music, and occupational therapies. Play therapy, specifically, was recommended to help Darren develop his symbolic and joint play skills along with his interpersonal skills. Early into the school year, the teachers and other therapists noticed Darren was preoccupied with people's heads and often went up to adults and other children to rest his face on their

heads. He was seen to hit his head frequently, seemingly accidentally; for example, he would fail to duck on the playground when he ran underneath a low structure. His occupational therapist commented, "he leads with his head." Despite this preoccupation with people's heads, there was no mention of any psychological sequelae of his trauma in the chart. It was only after meeting him for several sessions that his delays appeared to be rooted in his early medical trauma.

Of note, Darren's parents were not involved in Darren's treatment across all of the services at school. This writer, as well as the teachers and other therapists at school, made several attempts to involve his parents in his treatment. His parents were overwhelmed by social stressors and the care of their other children. They were only able to make one of the two major team meetings at the school and attended none of the individual meetings with the therapists (psychological, speech, or occupational).

Discussion of the treatment

Darren was seen twice weekly for one school year (nine months in total) in the therapeutic nursery setting.

Early treatment: Concrete representations of trauma

I met with Darren several times in the classroom before we met in a private playroom. Darren initially presented a bland affect, and it was rare to see him smile. He seemed dissociated and appeared to be in a perpetual daze. It was unclear whether his daze was due to anxiety about being in a new setting, since it was his first year in this school, or if this was how he presented across settings.

Though he walked around the classroom in a daze, he gained energy during our play when I played in an exaggerated way. For example, one of the first times we played in the classroom he pretended to feed me. I became excited to eat and then would groan, pretending to be full. As the play developed, he smiled as I acted full, and he would feed me at a more rapid pace, rushing to bring all of the food items he could find to feed me. This play is reminiscent of his needing a feeding/swallowing specialist postsurgery and even his need of a feeding tube while he was unconscious. With this play, he could take ownership of his experiences and be the active participator in the scenario rather than the passive recipient. Even when I acted full, he kept feeding me, and I wondered if his experience of being force fed passed his comfort level rather than helped him to eat. Another time in the classroom, I found him playing listlessly with small blocks in a plastic bin. He would pick a block up, and with a blank expression he would drop the block back into the bin. As the block hit the bin, I exclaimed, "drop!" Interested, he began dropping the blocks from greater and greater heights, and each time I excitedly exclaimed, "drop!" He began to smile and forcefully threw the blocks down into the bin. With my interest in his play, he almost instantly became enlivened. In both scenarios, I wondered how much his efforts of being heard were mirrored in an other.

In the therapy room, Darren readily began telling his story. The primary play sequence consisted of Darren asking me to lie down, which he indicated mainly through pointing, occasionally verbalizing "you lay down." He would then drape a knitted cloth over my face and operate on my head using pretend power tools. There were play doctor tools available, but his preferred operating tool was a play power drill. Every time he draped the cloth over my face, I feared something bad would happen. I could barely see, wondering what if he tripped and I could not anticipate his fall to catch him? What if, in his play, he would hurt me and I could not prevent it? I felt anxious and confused about what was going to come next, feelings Darren may have experienced when he was in the hospital.

Through this play, I was an active participant in enacting Darren's trauma. I played his infant self in this experience and fully entered into a play reenactment of his trauma. I served as a participating witness, recreating and representing his somatic memories of feeding tubes and repeated surgical interventions, which he readily directed and shared with me. By embodying his experiences, he was able to communicate to me, which was incredibly important since he did not have a wide expressive

vocabulary. Therapists often rely solely on the act of speaking as communication and as the method used toward symbolization, but much of our experiences are somatic or preverbal. Instead, using the metaphor of the play scenario to understand what is being communicated is crucial in hearing the preverbal or nonverbal child. Another key aspect of this work is for therapists to allow themselves to be used in the play to hold the emotions the patient is projecting. During this play, in carrying his projections, I felt some of the fear and anxiety he may have felt during his experience. This particular kind of communication, that is, having a witness mirror the projected emotions, is what Alvarez (2012) calls "whatness or isness," which paves the way for more advanced symbolization. On this level, the work is both about receiving and carrying projections and about helping the patient introject their projections (through mirroring, playing through the enactment, etc.). Understanding that I was feeling what he may have felt allowed me to vocalize what I imagined he wished to communicate, which can be seen in the excerpt below.

Excerpt from Two Months into Treatment

Darren: [walks to the toy shelves and grabs the tool box, struggles to lift it]
Therapist: Want me to take it?
Darren: [shakes head yes]
Therapist: [brings it to the table and opens it]
Darren: [points to the floor emphatically]
Therapist: [I lay down]
Darren: [goes to the babydoll crib to get the small knitted blanket, drapes it on my face]
Therapist: [in an affected/exaggerated tone] Oh I can't see. What's going on?
Darren: [goes through the toolbox and gets out a hammer, starts to hammer my forehead]
Therapist: Ouch my head! That hurts! I can't see, what's happening? [I can barely see through the knitting and I see his face is blank]. [In a hushed whisper] Darren can you please hit more gently?
Darren: [hits my forehead my gently, and then takes the drill and drills my forehead]
Therapist: Ah I am scared! I can't see, when will it end?
Darren: [switches back to the hammer, and hammers my arms, and knees]
Therapist: Ah my arms! My knees.
This scenario repeats two or three times.
Darren: [lifts the blanket off my face]
Therapist: Ah I can see! [takes a deep breath] I feel better now.
Darren: [takes a favorite book off the shelves, one that has big googly eyes on the cover, and brings it to me]
Therapist: Would you like to read this?
Darren: [shakes head yes]

Sitting on the floor, Darren sat in my lap and we read the book together.

This excerpt highlights the richness of Darren's communication. The small, white, knitted blanket that Darren draped on my eyes appears to represent the fogginess of anesthesia and serves as a way to surprise me about what is going to happen. The choice of hammers suggests the aggressive attacks experienced in his medical treatment, especially since there were more traditional doctor toys available that he chose not to touch. This sequence also highlights the somatic level on which Darren remembered his trauma.

Darren used this play sequence as a way to witness his trauma, and to be witnessed, as in an effort to shed the role of victim by acting as the perpetrator. Though Darren played the perpetrator, he exhibited an advanced ability to regulate his behaviors. He would often use a hammer on my head to represent the surgery, but when I asked him to be gentler he would do so immediately. At this point in the treatment, Darren needed not containment as much as the space to enact and make meaning of his trauma. After he had done the work of communicating his experiences, there was a moment of integration where Darren sought to join me in a calming activity (e.g., reading to him).

Through our joint enactment and my verbalization of our experiences, Darren gained energy and exhibited more affect. Through this play, he was able to transform his experiences into a more symbolic representation. This direct surgery play evolved into operating similarly on plastic baby dolls, but without the blanket covering them. He would hit their heads, eyes, and back. I viewed this transition as showing me the attack on his infant self, and I reacted by caring for the infant in a way he may have wished to be cared for. I would say, "oh the poor baby," then I would label the body part he hit and scoop up the baby, kiss or stroke the baby, and then we would repeat the sequence. He would also drop the baby on its head, and I would react similarly. He smiled and giggled when I took care of the doll, which is one of the first times he consistently smiled during the play. During this play he continued to be able to modulate his expression of affect.

During one session, I thought that instead of soothing the baby after it was hurt I could protect the baby from harm. I had felt hopeless and stuck in the cycle of seeing the baby repeatedly hurt, and I felt it might be reparative to play through a scenario where the baby could be protected from danger. He appeared confused at this change and began trying to harm the doll by throwing toys at the area where I had hidden the infant to protect it from harm. He became increasingly upset, furrowing his eyebrows and screaming. My interventions of talking through my protection of the baby did not soothe him but rather dysregulated him, and he was unable to regain regulation until I presented the child to him. Our typical play sequence resumed, and he smiled when I cared for the child.

In retrospect I think I became fatigued and disheartened at having to witness the repetitiveness of Darren's trauma and instead acted on my wish to have been there to protect Darren from what happened to him. In providing a false solution, I cut off Darren's ability to express what *he* needed to communicate. This session illustrates the importance of allowing traumatized children to lead the sessions and for therapists to be fully invested participants in recreating the children's experiences of their traumas. This is not to say therapists should not attempt to introduce protective elements to the narrative, as I certainly did with my soothing the baby doll. However, my mistake in this session was not being aware that I was changing the narrative altogether, out of my needs instead of Darren's. No relationship is without rupture, and in particular the therapeutic alliance benefits from ruptures that are repaired successfully. Ruptures are common in therapy, and if they can be negotiated successfully it can be a corrective experience (Eubanks-Carter, Gorman, & Muran, 2012). Being attuned to pauses or strains in the play is crucial in noticing if a rupture has occurred.

Middle treatment: Oral aggression or introjection?

In what seemed to be a sudden transition, Darren shifted away from a direct recreation of his traumas to play sequences that encompassed aggression in the form of biting and eating. During this new play, Darren expressed a wider range of emotions, becoming more lively and smiling more easily. This achievement was accompanied by increased representational elements in the play, marked by the use of dinosaurs and puppets rather than our own bodies and a baby doll.

Darren continued to primarily play the role of the aggressor through his choice of a dinosaur toy while I played the victim through the use of various puppets. Darren would use the dinosaur to bite one of my characters. Continuing the play in the prior phase of treatment, I used a third character to dramatize the expression of emotions while trying to protect the victim character. When the victim character was attacked, I cried out to express my character's emotions, while the third character would tell Darren's dinosaur to "leave my friend alone!"

Initially, my characters reacted with sadness or distress when Darren's dinosaur bit them, and Darren reacted enthusiastically to these enactments. However, over several sessions his excitement waned and the play became more robotic. I, too, became somewhat bored with the repetitive nature of this play, and began to feel hopeless about our ability to symbolize this experience. It felt like a loop of aggression and victimization. Alvarez[1], in discussing this case, pointed out that a countertransference of boredom or hopelessness may be a sign the child is acting sadistically or perversely. In reflection, I think in Darren's case I was not initially sensitive to his communications.

The boredom seemed to be related to the repetition of sympathy for the victim, with no way out of the victimization, in what became a reenactment of passivity in the face of sadistic attacks. Darren needed a way out he could claim for himself. I switched to having my characters react angrily and actively protect themselves from the dinosaur by running away. Darren instantly became enlivened and reacted more excitedly when my characters protected themselves and expressed anger when my characters reacted with fear and sadness. He could then identify with my power rather than submitting and succumbing to anesthesia, that is, the anesthesia of his medical procedures and the consequent emotional anesthesia of the trauma. We both felt enlivened by the new mastery my characters gained in defending themselves and thwarting the aggressor.

This shift marked a new phase in the treatment. Although it seemed Darren was able to mourn his trauma when my characters expressed sadness, he needed more than empathetic acknowledgment of his victimization. He needed to tap into a sense of his own power, his own ability to overcome past damages. Did I fear Darren's aggression? Was I playing out my own sadness and feelings of hopelessness in the face of Darren's relentlessly attacking dinosaur? When my characters shed the role of victims needing protection and could protect themselves, Darren was able to express his aggression without destroying them, and then he, too, could feel he was not being destroyed in the face of trauma. The excerpt below illustrates our newfound joint power.

Excerpt from Four Months into Treatment

Darren: [runs into the playroom, straight to the puppet/stuffed toy shelf. He gives me my usual puppets (a girl, and a pig, and I put them on my hands- while sitting on the floor). Then he grabs the big plastic dinosaur from the animal bin. He begins eating my pig puppet].
Therapist: [using the girl puppet to speak] Hey, don't eat my friend! Go away!
Darren: [giggling, used the dino to eat the girl puppet]
Therapist: [using the pig puppet to speak] Don't eat my friend! [using the pig puppet arms, attempts to pull dino off the girl. When the dino is off, the pig consoles the girl] Are you ok? [puppets hug]
Darren: [giggling, then switches back to the pig]
Therapist: [Using the girl] You are making me angry, don't eat my friend! [pushes dino off the pig puppet, using girl puppet arms, consoles pig] Oh my poor friend, are you ok?

The eating play continues to repeat similarly several times

Darren: [puts dino down, and points to the play barn, which I get down for him. Then he gets small people figures, and gives me a girl. He takes the dino, puts the barn between us, and using the door of the barn he stuck the dinosaur's foot out of the barn] Eat my foot.
Therapist: [using the figure, my figure bites the dino's foot]
Darren: [hits my figure]
Therapist: [speaking from the figure] Ouch! You hit me!
Darren: Eat my foot!
Therapist: [using the figure, my figure bites the dino's foot]
Darren: [hits my figure]
Therapist: Ouch! Hey what did you do that for?
Darren: Eat my foot!
Therapist: No! I get hurt when I eat your foot.
Darren: Eat my foot!
Therapist: [using the figure, reluctantly my figure bites the dino's foot] Ok
Darren: [hits my figure] Eat my foot!
Therapist: Ok, you want me to eat you, but you don't.
–This repeats once, then Darren grabs the school house–
Therapist: [Darren's dino chases my figure] Oh no! I am scared!

Darren: You scared?
Therapist: [speaking from figure] Yes! The dinosaur will eat me!
Darren: [picks up a human figure in other hand, joins my figure in running from the dino. Dino bites my figure and Darren's figure]
Therapist: [using figure] Ah! We are being eaten, what should we do?
Darren: [using figure] What should we do?
Therapist: Lets fight the dinosaur!

Both attack the dinosaur using our figures, Darren is smiling and enthusiastically attacking the dinosaur with my figure. Together, we then lock the dinosaur in a drawer.

Therapist: Whew! We did it.
Darren: [catching his breath, sighs]

This excerpt exemplifies the way in which fighting back became playful. He could take in my anger (my biting his foot) so that he could fight back and gain autonomy and not be a passive victim. Rather than perverse repetitions of sadism, his biting became a form of an insistent projective-introjective cycle that was being modified by a powerfully loving identification. Folk singer Woody Gunthrie (1946) wrote a series of songs in 1946 that were inspired by his experience as a father to his then young children. What follows are an abbreviated selection of lyrics from his song "I'll Eat You, I'll Drink You" from this time period, highlighting the lovingness of oral aggression and introjection.

"I'll eat you I'll drink you,
Yum yum yum yum yum…
Well, I'll eat you and you'll eat me,
Sody pop, ice cream, sugar in my tea…
I'll bite you, I'll chew you…
I like you I love you…
I smell you I taste you,
I touch you I'll feel you…"

When Darren first played through this theme of attacking through biting, I thought Darren had moved away from playing through his traumatic experience at the hospital. I thought Darren was perhaps working through some experience of relational aggression or perhaps a developmentally appropriate orality that had been denied him at the earlier point of trauma. In one session, we entered the playroom and the dinosaur was missing. Other therapists shared the playroom, and the toy may have moved to another room. I apologized to Darren, but without missing a beat he handed me my usual characters. He then became the dinosaur-doctor, manipulating the tools from the doctor kit while roaring and eating other characters. Surprised, I went through our sequence of actively confronting and evading the other from the dinosaur-doctor, and we moved on with the session.

I was impressed with Darren's symbolic representation of processing his trauma. The angry eating dinosaur was a metaphor for the aggressiveness of his surgical experience. The anger expressed by my characters, who represented Darren, afforded him the agency to fight back, which was a new experience for him. He shifted from showing me concretely and somatically what happened to him (i.e., the baby doll being dropped and injured) to showing me how he felt (the anger, sadness, and fear). Additionally, his affect expanded with this movement from the concrete to the metaphorical. He went from a withdrawn and flat demeanor, with rare smiles, to an excited enlivenment, frequently smiling and jumping.

During this treatment phase, I tried introducing a feeling chart to help Darren label his emotions. He refused to label them himself, but he would point to a feeling and then point to me. I would act out the emotion he indicated, and he would smile and become excited. Sometimes he pointed at emotions in rapid succession, and I would have to keep up. He seemed to need me to express these emotions for him. Did he need to learn to discriminate one feeling from another? Or did he need my

permission, my acknowledgment, to feel at all? Together we experimented trying on different emotions. Throughout the treatment, Darren was able to dislodge his previously frozen reaction to his trauma and gradually expand his emotional repertoire.

End of treatment: Increased symbolization, and the path toward sharing and perspective taking

One theme that wove through all of the treatment phases was that of protecting and saving characters from harm. However, in this final treatment phase, Darren gained flexibility in his play and in his emotional expressiveness. A new theme of sharing emerged toward the end of treatment in the context of sharing food. In addition to his newfound flexibility, the theme of sharing food may also have re-emerged since Darren's baby brother was born around this time. Darren's mother said that at home he enjoyed feeding the baby, as he had done with me in our initial meetings when he fed me play food. But this feeding had a different quality; no longer frenzied and forced, more like an aggressive attack, it was beginning to take on a quality of sharing lovingly. With his brother, Darren was able to feed as a way to help another grow. This shift toward sharing occurred in the treatment room as well, though not without some struggle.

After the birth of his brother, Darren's play became more angry and chaotic, but at the same time he also became more verbal. He began prompting me to play a certain way through verbal direction rather than pointing, and he labeled emotions more readily. He moved away from having me act out the emotions on the feeling chart and began to be able to act them out with me when I pointed to the different emotions. The first emotion he labeled on his own was "scared," which I think was a particularly salient emotion for him. Darren's increased ability to symbolize was accompanied by, and perhaps predicated on, an increased ability to access the emotions previously frozen.

Though more verbal and able to access a wider range of emotions, Darren also became more dysregulated and engaged in more manically excited play, particularly when he would attack my characters. The dinosaurs and animals fought, and they shot at each other using toy guns Darren and I built together. This play was confusing: at one moment I would be teamed with a character fighting another in a two-against-one scenario, and in a sudden reversal my teammate character would become the enemy and attack me. It was as if I could never know when the harm was going to come or from whom. It became impossible to trust any of my supposed allies in the play. The following excerpt illustrates this confusion.

Excerpt from Eight Months into Treatment

Darren: [gets a baby figure, parent figures, a truck with a crane that he has previously used to attack figures' heads. In this session he had the truck roar- which I believe is a stand in for the doctor/dino. He gave me the little girl figure, which holds a little apple in her hand]. [roaring for the truck, he chased the baby].

Therapist: Oh no the baby is in danger!

Darren: [truck hits the baby]

Therapist: Ah the baby is hurt! What can I do?

Darren: [using the parent figures, hits the truck]

Therapist: Oh the parents are saving the baby.

Darren: [using the crane, hits the baby across the room]

Therapist: Oh no! [scoops up the baby figure] poor baby is hurt. [strokes the baby doll, then sets the baby down to repeat the play].

This repeats where he hits the baby across the room, the parents attack the truck, and I console the baby

Therapist: [using the girl figure] Ok baby, I am going to hide you in the drawers.

Darren: [the truck hits the drawers]

Therapist: [using the girl figure] Truck go away! I am angry you want to hurt the baby!

Darren: [parent figures continue to attack the truck. Then takes the doctor figure and hits my girl figure]

Therapist: [from girl figure] Ouch! Oh no don't hurt me, I am scared!
Darren: [doctor continues to hit girl, speaking from parents] give me the apple! [parent figures start to bite the girl's apple, while doctor continues to attack her. The fighting becomes confusing, everyone attacking the girl]
Therapist: [from the girl] That is my apple! Don't take it. I am so confused, everyone is trying to hurt me!
Darren: I am taking you apple!
Therapist: No don't! [attacking continues]. Oh I am so sad, please don't take my apple, don't take my love!
Darren: [brings in a new figure, a grandmother, who begins to protect the girl. The grandma hits the parents] Don't take her apple! [grandmother gives girl back her apple]
Therapist: Oh thank you grandma!

This sequence repeats.

This session demonstrates Darren's further ability to metaphorically represent his experiences. In this session, family members hurt and steal food/love from one another. I surprised myself by saying, "don't take my love," which led me to wonder what the apple (and perhaps all the play food previously fed/shared) may have represented for Darren. I believe Darren was likely working through sharing his parents' affection with a new baby, which may have reactivated the abandonment by his mother and his relinquishment to the surgeons in the hospital.

Though food was sometimes stolen from characters, sharing became more predominant in our play. During one session, his dinosaur was trying to eat my characters, and instead of attacking the dinosaur back I asked if the dinosaur was hungry and wanted some food. Wary, Darren nodded yes, and I retrieved a plate of pretend food. Darren initiated the sharing, and as his character ate voraciously, he offered to share the food with my characters. Through laughter, we rapidly shared food back and forth and Darren began calling my characters "bros" as they shared the food. This theme of sharing came up regularly after this introduction and was a welcome reprieve from the confusing attacks that were frequent during this time. He began greeting me in the classroom with "I found you!" This play was a rejoining, where we both could come back to the sharing relationship we built over the course of the year.

Concluding remarks

This clinical case lends evidence to the efficacy of psychodynamic play therapy for the treatment of preverbal trauma. Traumas are often stored somatically (van der Kolk, 2014), especially when they occur before children develop verbal language. By embodying Darren's transference, the therapist allowed Darren to communicate his emotions and to witness his experience. The experience of joint witnessing helped Darren transform his experiences from frozen reenactments to metaphorized play. With this transformation, Darren's previously dissociated emotions emerged and he was able to flexibly express his feelings both verbally and through play.

Melanie Klein (1930, 1955) underscores the significance of somatic experience in the development of the symbol. For her, the symbol comes into being through the dialectic experience of the body of the self in relation to the body of the other (see Lombardi, 2006 for a fuller discussion). The traumatized child, especially the child attacked or compromised on a somatic level, presents a particular case where symbolization may be interrupted in encapsulated areas, if not delayed altogether. The work of therapy is in reaching the child on the level of the trauma, which is largely preverbal. To refer to Stern's (1985) work, even when language and symbolization are achieved, the insult is to the core or bodily self, which is addressed therapeutically through bodily metaphor. In infants and young children, as is Darren's case, the memory of the trauma is encoded in the body before language develops, and therapy takes place on the level of enactment (Lombardi, 2002), a presymbolic plane that moves toward representation. Winnicott's

(1971, 1977) work with play encourages such engagement. His work with the Piggle echoes the feeding episodes with Darren, as he says to his patient Gabrielle: "Winnicott is the Piggle's baby; it's very greedy because it loves the Piggle, it's mother, so much, and it's eaten so much that it's sick" (1977, p. 25). Gabrielle, a neurotic 3 year old, can take in these interpretations in ways that are often not available to less verbal or more damaged children. For that we look to Alvarez (2012), particularly to her conception of levels of interpretation with disturbed and developmentally impaired children. Before cause and effect, "Why?" interpretations are what Alvarez terms "Whatness or Isness," work on a descriptive level that names experience and emotion and functions to initiate and enlarge meaning. "Whatness" works on the level of need and protection, both containing projections and facilitating introjections. Much of the work with Darren took place on the level of "Whatness," where the focus was initially on protection and containment and moved to enactments that increasingly facilitated introjections related to power and mastery. But even before that, Darren, who initially presented as dissociated, seemingly in a perpetual daze, needed to be woken up. This earliest level Alvarez refers to as "A Call – Hey!" In the initial meetings with Darren, the central therapeutic interaction was to raise the level of aliveness, to call him to attention through the presence of the therapist, for example, to exclaim "drop!" when he was listlessly playing with blocks in a plastic bin or to groan loudly from satiation when he fed her. The culmination of the work with Darren was in his new greeting to his therapist toward the end of their work together, the exclamation "I found you!" He had also found himself.

Finally, this treatment of Darren highlights the importance of twice weekly play therapy for traumatized children. Though this treatment took place in a school setting, we may safely generalize this type of treatment to a private practice or community clinic setting, as long as the children receive other necessary services/therapy alongside psychotherapy (speech/language, occupational, music, and special education).

Darren was able to begin to metaphorize his experiences over the course of the school year, and his verbal and symbolic expressions significantly increased since he attended this enriched preschool school environment. We want to stress the importance of school-based services, not just psychotherapy but also occupational, speech, music therapy, and special education, all of which Darren received concurrently to the play therapy. We are not sure we would have been able to make the gains we did without all of the services provided by the school. While the play therapy allowed Darren to have the space to express and symbolize his trauma, occupational therapy strengthened Darren's fine and gross motor skills so he was able to play with more advanced toys and helped his body gain strength. Speech therapy aided in Darren's verbal expression and reception, music therapy provided space for nonverbal emotional expression and joy, and special education helped Darren think more flexibly. Changes in emotional expression and symbolic play take time, and long-term therapies offer the chance for children to develop their full potentials and to slowly work through adverse experiences.

Note

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