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GO WITH THAT

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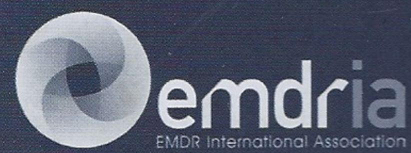

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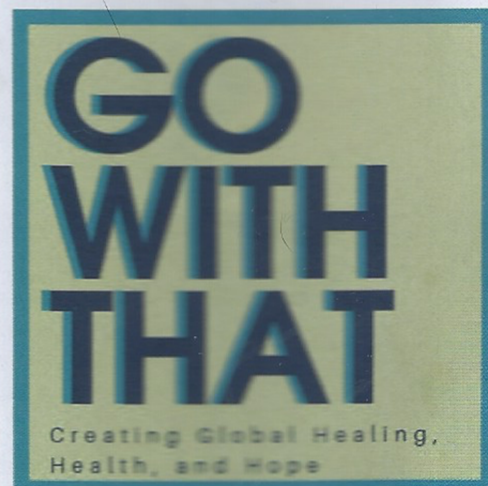

Exploring the Intersection of EMDR and Play Therapy

ANN BECKLEY-FOREST, LCSW-R, RPT-S

American psychologist, educator, and founder of EMDR, Francine Shapiro's adaptive information processing (AIP) model proposes that the integration of both positive and negative experiences into our nervous system is the healthy process by which we grow. When an acutely negative or traumatic event occurs, our own neurobiological effort to cope with the trauma sabotages this information processing by isolating the related associations, images, feelings, etc. (Shapiro, 2017).

EMDR's potency in entering this isolated memory network and enabling the client to begin the adaptive process of integration is well established. In the field, professionals are now looking into the intriguing question of how EMDR does its work and, often the more complicated question, how can EMDR professionals best get each client to do it?

Making safe therapeutic space for the activation and the adaptive processing of traumatic memories has long been a central theme in play therapy literature.

Basis for Integration

Since the field's earliest days, practitioners have attempted to extend the benefits of EMDR to children (Greenwald, 1999), which has a growing body of evidence in support of it (Adler-Tapia & Settle, 2009). However, therapists trained in EMDR often have great difficulty getting children to participate in EMDR activities in clinical settings.

In considering what AIP looks like in children versus adults, it is essential to recognize that children do the majority of their learning through action and imaginative experimentation, not through the verbal reflection or even the visual imagery that is the primary portal of processing for most adults using EMDR.

An all-too-typical clinical situation that an EMDR therapist might encounter in a younger child follows along these lines: the therapist brings up the target memory verbally and follows up by using "feelings faces," or a cutout of the body, for the assessment of the memory target. These props are definitely useful in translating the language of the standard protocol – and the child answers but appears bored or detached. The therapist uses bilateral stimulation (BLS) for a few sets and checks in with the child. The child either reports that it's fine now, asks to stop, or becomes disruptive and refuses to continue.

While children with strong verbal capacities do participate in child-friendly standard protocol approaches, such as the one described above, this processing often feels superficial in practice. The therapist may wonder if the child is just going through the motions and may be unsure if the neural nets are activated to the extent needed for processing to occur. If child therapists want to be effective in extending the benefits of EMDR to more children, they will need to bring all of their creativity, playfulness and co-regulation to make these moments a possibility.

Power of Play Therapy Settings

Making safe therapeutic space for the activation and the adaptive processing of traumatic memories has long been a central theme in play therapy literature. This foundation should be the basis of the intersection between these two approaches to helping children heal. The significance of adding EMDR to the digestion of engaging experiences that children are already having in the play therapy room has been driving many trained play therapists to seek EMDR training. This trend holds the promise of moving beyond merely making EMDR more palatable to children toward a model that fully integrates both approaches.

A prescriptive approach to play therapy is quite compatible with integration of the eight phases of EMDR.

In moments of play, neural networks activate more fully and offer opportunities for more adaptive information to enter those networks. The elements of adult neutrality and acceptance, child agency, and what play therapist and author Terry Kottman calls the "egalitarian relationship between therapist and child" (2015) are critical to the construction of emotional safety in the play therapy room. The neutrality of tracking the child's own play and being fully present to the child in traditional Child-Centered Play Therapy (CCPT) constitutes the foundation for a unique relationship between the therapist and the child.

Practicing Neutral Engagement

This relationship expands the possibility for the child's own resolution of disruptions (for a thorough grounding on the theory and methodology of Child Centered Play Therapy, see Landreth,

2012). The therapist stays connected by neutrally following and reflecting the child's actions and consistently noticing the child's own agency in the play room, using phrases such as, "In here, you can decide," or "You are thinking of what you want to do now."

Clinical wisdom regarding trauma therapy with young children forces us to recognize how easily the therapeutic alliance is compromised by a child's adult-pleasing or adult-defying behaviors. Therapist neutrality, in particular the intentional creation of the play therapy space as described by CCPT, increases the projective power of the space to hold the experience of the child authentically, without the distraction of trying to please or oppose the adult. This kind of neutral engagement is a rare experience in the lives of children. In traditional or pure CCPT and its companion approaches with families, filial play therapy and Child Parent Relationship Therapy, experts believe the child's own system is able to heal itself if the therapist can sufficiently hold the therapeutic space.

Flexibility of Prescriptive Approaches

In current play therapy practice, many play therapists have turned to a more prescriptive approach. They borrow from CCPT but may choose to direct some activities based on the need of the child, especially in light of trauma research about the avoidance of trauma memory networks.

Prescriptive play therapy approaches are flexible. They use a mixture of child-centered play time, as described above, along with child-responsive interventions from the therapist, such as adding adaptive information or options when the post-traumatic play appears stuck. Play therapy training encourages the therapist to use the lightest touch possible with these insertions, such as wondering aloud, "I wonder what would happen if...."

These kinds of observations can help shifts in thinking to be more congruent, much like the gentle language that EMDR therapists use along with interweaves in EMDR processing. In ad-

On A Personal Note: Post-Trauma Play in My Practice

In my clinical practice, I have found the possibility of approaching the trauma network gradually through play extends beyond the sand tray to many of the imaginative role-playing activities in the play room that many children favor, such as the baby play that younger children with insecure attachment often present in the play room.

A young client, with insecure attachment stemming from her addicted mother's inconsistent care in infancy, used the child-centered play therapy time to again and again re-enact a similar story with herself. As a baby figure, she is alternately cared for and threatened by the imaginary characters in the room, played by the therapist and various stuffed animals and toys at her direction.

Over time, the therapist allows the client to be in charge of the play as its director. The client adds more and more elements of her ambivalent attachment into the play. For example, the client has the therapist act as the mother figure ("Mother") in the dramatic play, while the client plays the role of the baby ("Baby"). Sometimes Mother takes care of Baby and feeds Baby in this drama. (This client began bringing snacks into the session for this purpose. At times, she used a water bottle as the prop.)

At other times, the client directs Mother to tell Baby that Baby is lying, that Baby cannot have the things Baby wants. The client also directs Mother to tell Baby that Baby cannot sleep or be distracted when a dangerous third character, "X," in the form of a seen or unseen presence, comes into the room and threatens Baby in the drama.

This drama had many of the qualities of dynamic post-traumatic play, including urgency to the child, a sense of felt reality and emotional intensity as well as thematic parallels to the child's own experience. In this setting, she was able to convey to me the negative beliefs and emotions experienced by the baby. During brief sets of BLS (in this case most often tactile BLS with Patty Cake type of hand claps bilaterally across the line of sight), she was able to notice the distress in her own body. Gradually the self was brought more explicitly into this processing using the bridge of this play, initially quite simply by noticing, in statements such as, "You were a once a baby who knows what that lonely feeling is like."

This child could not have tolerated a standard protocol approach and, as much of the trauma was preverbal, she would not have had the words to convey the magnitude of her experience. Through the play, she was able to activate that memory network and use the opportunity to digest her anger and fear in an embodied way (sometimes by throwing the stuffed animals or using other active means). By using the BLS to focus her moments of noticing, we were able to begin to shift the play with the slow introduction of adaptive information.

This flexible approach to desensitization and reprocessing must be grounded in all the elements of the standard protocol, with attention paid to the images, emotions, negative beliefs, and body sensations, but the process is more spontaneous and driven by the narrative of the play.

dition, prescriptive play therapists use information gained through tracking child-centered play to develop a menu of play-based skill building activities for the child and family to complement the play in which the child is already engaging. A prescriptive approach to play therapy is quite compatible with integration of the eight phases of EMDR.

Author-Expert Support of Play Therapy

In her book, Play Therapy with Traumatized Children (2010), licensed clinical social worker and registered play therapist-supervisor Paris Goodyear-Brown proposes a model for Flexibly Sequential Play Therapy, a phase model which she now calls TraumaPlay. Her model is an integration of directive and nondirective play therapy activities prescribed to 1) develop emotional safety, 2) promote physiological soothing and emotional modulation, 3) allow for gradual exposure to the traumatic material in order to re-order negative beliefs, and 4) make sense of the self in light of the trauma.

Eliana Gil, another play therapy author, lecturer, and clinician of marriage, family, and children, describes post-traumatic play as a repetitive and often rigid type of play initiated by children who are trying to "expose themselves to the literal aspects of the trauma which cause them despair" (2012, p.184). In the AIP model, therapists would describe these elements in the play as connected to the memory node, which holds the trauma, thus offering a possible pathway into the associated neural net. If the child is able to gradually move in and out of this processing in a dynamic way, the brain's own drive toward integration will promote healing.

Gil's work within play therapy has been significant in helping play therapists with the complexities of recognizing and supporting dynamic play, which may be post-traumatic in nature, providing options for intervening to prevent the play from becoming static and potentially re-traumatizing, as well as using play to ground children who begin to dissociate (Gil, 2016).

The autonomy of the child in the rich sensory environment of the playroom helps to mitigate the risk of children becoming overwhelmed and dissociating during post-traumatic play. In the presence of play that suggests post-traumatic content, a play therapist also trained in EMDR may be able to accelerate this processing with the child.

How-Tos of Integration

In her book, EMDR Therapy and Adjunct Approaches with Children: Complex Trauma, Attachment and Dissociation, psychotherapist and international lecturer Ana Gomez presents one of the best published examples of how to fully integrate EMDR into a play therapy setting in her development of a protocol for using EMDR in the context of the sandtray (Gomez, 2012). A sandtray and a collection of miniature figures chosen deliberately for their projective possibilities are standard materials available in a play therapy room. Children gravitate toward these as a place of both active and dynamic play as well as the setting for intentional creation of scenes with symbolic power for the child (Homeyer & Sweeney, 2011).

Gomez describes how invitations to children to create stories in the sand tray help to more gradually approach the traumatic memory networks available in imaginative play. The therapist might begin some initial processing along the networks that the child is not yet ready to explicitly approach in metaphor of the play (Gomez, 193-196) by wondering about the thoughts, feelings, body sensations of the central character, or self-object, in the play, and asking the child to notice these along with BLS.

Summarizing the Essentials

If therapists want to make space for EMDR in the context of prescriptive play therapy, here are several key considerations:

1. An initial phase of child-centered play helps to establish the egalitarian relationship. It allows the emergence of play, which may already activate the trauma memory network and provide information to the therapist about the child's experiences of the trauma, especially when verbal disclosure may be difficult if not impossible. The therapist allows this material to emerge congruently, without activating the child's defenses.
2. The distancing of the play allows the child to stay more present, even as traumatic intensity emerges, especially when the child has a lot of fear of the memory or the memory is beyond the child's current awareness.
3. Use gradual, play-based introduction of eye movements, BLS, EMDR tools, and vocabulary, initially for installing and noticing positive moments and associated body sensations.
4. Before or after the child-centered play time, introduce more directive activities, which promote state change from distress to calm. In addition, introduce generally developing resources as preparation for approaching the trauma. Play therapy literature, including material referenced below, offers many options compatible with these goals including Theraplay, and other directive approaches (Schaefer & Cangelosi, 2016).
5. Initial EMDR processing of trauma content can occur in the context of the play metaphor using the characters in the story for the initial assessment of the target and beginning reprocessing.
6. Build bridges from the play to the child's own experiences. Use short episodes of EMDR processing with BLS to notice the upsetting body responses or beliefs in a child-responsive but not highly directive way.
7. Parents and caregivers must be involved for support and as a resource.
8. Because it is quite challenging for young children to use the SUDS scale accurately (they tend to report everything as either a 10 or 0), Annie Monaco, LCSWR, an international specialist in trauma resolution methods, promotes the use of caregiver interviews for Phase 8 re-evaluation of targets (Monaco & Beckley-Forest, 2016). It is important to continue to return to processing in small chunks as needed as well as to attending to the shifts in the child's play themes as a clue about

the remaining distress.

Next Steps

One of the compelling reasons for encouraging more cross-training for EMDR trauma therapists as play therapists is the number of children who are the hardest to reach in therapy – those with complex trauma, especially resulting from maltreatment by caregivers. Attachment trauma presents the most challenges in establishing a window in which children are able to digest and accept adaptive information into the memory network and then begin to heal.

Child-centered play therapy approaches are not easy to master, especially with children who have attachment trauma. Its aftermath and attempts to prematurely initiate a directive therapy are often doomed before they begin. Advanced training in play therapy prepares the trauma therapist to stay grounded themselves and hold open the space in which the child can begin to show their wounded self in the play.

Licensed professional counselor and registered play therapy supervisor Lisa Dion electrified the play therapy community in her recent work. She applied recent advances in neurobiology to further develop the idea that the therapist's ability to recognize and resonate – and even exaggerate – the emotional landscape that the child is projecting in the play is the agent of change in play therapy (2018, p 105). Ultimately the attunement of the therapist makes the success of efforts to promote digestion of the trauma with EMDR more likely to succeed, and the dance that is established between therapist and client in play therapy helps keep the child within the neurobiological window of tolerance and not dissociating or overwhelmed.

Those trained in both approaches promote the idea that play therapists benefit from using EMDR therapy as a way to navigate the process of drawing children into first-person trauma work to heal more quickly, even when the child's own nervous system is organized around walling off those experiences.

With increasing numbers of therapists credentialed as both play therapists and EMDR therapists comes the possibility of more training and research focused on the efficacy and benefits of EMDR for our youngest clients. Of the need to offer healing to children as early in life as possible there can be no doubt.

Ann Beckley-Forest (annbeckleyforest.com) is a licensed clinical social worker and registered play therapist.

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An Example of Bridge Building

A child witness of domestic violence develops a drama in the dollhouse, using superheroes and villain figures. On the surface, it might seem like a fairly simplistic replay of action scenes from superhero movies. However, his persistence in returning to this when supported with child-centered play therapy allows the narrative to unfold and begin to carry meaning and content from his trauma experiences. He eventually expands the story to include a helpless younger sister figure, whom his hero character needs to rescue from bullying by the villain over and over again. Recognition of how this narrative carries the trauma content of standing helpless while his mother is beaten and wishing to be strong enough to protect and defend her, helps to create opportunities to bridge from the play into explicit trauma work. In these moments, using BLS helps his therapist notice the boy's own intolerance of bullying, his physical desire to defend the helpless, and only gradually approaches the explicit memory of wanting to save his mother. The boy's therapist used BLS with foam swords and drums to embody the intensity of this processing.

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