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# Trauma: Integrating Play Therapy and Eye Movement Desensitization and Reprocessing

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Theresa Odden

# Trauma: Integrating Play Therapy and Eye Movement Desensitization and Reprocessing

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Winona State University

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College of Education

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CERTIFICATE OF APPROVAL

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Capstone Project Supervisor: Dawnette Cigrand _____

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Abstract

Trauma has been documented for hundreds of years. Anyone can experience symptoms of trauma. Wamser-Nanney and Vandenberg (2013), discuss different types of trauma including, physical, sexual, domestic, medical, natural disaster, and terrorism violence. Symptoms from trauma can result in Post-Traumatic Stress Disorder (PTSD). PTSD is a result from a traumatic event that occurred. It can alter the brain and leave long lasting psychological symptoms (Bremner, 2006). Treatment for PTSD has focused around using exposure or cognitive therapies to help clients work through their traumatic event. Beckley-Forset (2015), discussed using an alternative therapy to work with trauma. She integrated play therapy and eye movement desensitization and reprocessing, while working with a young child who experienced a traumatic event. Integrating play therapy and EMDR, gives the therapist and client flexibility. These therapies integrated a directive and non-directive approach to working with trauma. Trauma can be hard to describe or talk about. Play therapy provides the opportunity to play out or express their trauma without words. Using EMDR with the bilateral stimulation, help the brain reprocess and store the trauma without further triggering the client. The integration of these two approaches provides therapists with methods that meet the developmental needs of clients who have experienced trauma.

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**Trauma: Integrating Play Therapy and Eye Movement Desensitization and Reprocessing**

Trauma is experienced by many people in this world. It can be a life altering event or incident that leaves a lasting imprint. Trauma is subjective; different for every person. Trauma is a psychological or emotional reaction, due to an event that is distressing or disturbing. It can be a physical, sexual, emotional or mental experience. An event such as domestic violence, war, medical issue or natural disaster could result in a traumatic experience. Because of the idiosyncrasy of each traumatic event and each person's response to it, a single incident could be processed in multiple different ways. Each individual with experience it through their own personal lens or outlook on life. According to SAMHSA-HRSA (n.d.), trauma is a single or series of situations that can impact an individual on several levels, mind and body, which leaves a lasting impression on their life.

Counselors help to treat the lasting impressions left by traumatic events. There are a multitude of options as to how to treat trauma in the counseling setting. Amaya-Jackson and DeRosa (2007), discuss evidence-based treatments in treating childhood trauma. It is stated child-parent support compared to individual treatment has a significant outcome in decreasing symptoms. Trauma-Focused Cognitive Behavioral Therapy is preferred over supportive therapies (Amaya-Jackson & DeRosa, 2007). According to Cloitre, Courtois, Charuvastra, Carapezza, Stolbach, and Green (2011), they surveyed clinical experts on what treatment approach was best when treating trauma and 84 percent recommended a sequenced approach when working with trauma clients. They state one should develop a treatment approach tailored to the clients' needs, which could include emotion regulation, anxiety and stress management, mindfulness, and cognitive restructuring of the event (Clotire et al., 2011). Other researchers, Raza and Holohan (2015), state using cognitive processing therapy or prolonged exposure therapy is preferred to

treat trauma in veterans. Their criteria on which one is most useful, is based on clinical surveys, determining treatments based on the client's literacy or guilt/shame levels.

Deciding which therapy to use with a trauma client is very important. Therefore, through a literature review, this author will discuss different types of trauma, theories to treat trauma, and how integrating play therapy and EMDR could potentially help children process trauma more quickly. Specifically, two evidence-based approaches already used to treat trauma, will be integrated. Play therapy is utilized with children, because it works without the child having to use words to express their thoughts and emotions. EMDR is a protocol used to treat trauma by helping the brain process the information fully. These are considered an integrated theoretical approach to be used in tandem to treat trauma.

## Review of Literature

### Types of Trauma

Trauma can be a single event, or a series of events, that leave a lasting psychological impression SAMHSA-HRSA (n.d.). According to the American Psychological Association (2019), trauma is an emotional response to a distressing or disturbing experience that results in shock or denial, flash backs, strained relationships, physical reactions, or emotional stress. The National Child Traumatic Stress Network (n.d.) reports trauma is the experience of being involved with or witnessing a threatening event, that leaves a strong impact on the child.

Wamser-Nanney and Vandenberg (2013), states there are a range of traumatic experiences. They discuss physical abuse, sexual abuse, domestic violence, medical trauma, natural disasters and terrorism violence. Wamser-Nanney and Vandenberg (2013) discuss how if the trauma was interpersonal or non-interpersonal make a difference in the severity and chronic outcome of trauma symptoms. Physical abuse is generally defined as acts of violence against a

person form another person who is caring for them. It results in injury such as cuts, bruises, broken bones, and red marks. Legally speaking, physical abuse can be different in every state; however, most laws are similar in definition (The National Child Traumatic Stress Network, n.d.). Sexual abuse is defined as sexual interaction between a willing and non-willing participant. Sexual abuse does not mean only physical touching behaviors, but non-physical behaviors as well, as defined by The National Child Traumatic Stress Network (n.d.). Briere and Runtz (1987), discuss sexual abuse as being harmful and resulting in psychological dysfunction. It states sexual abuse between an adult and child can result in the victim feeling guilty, depresses, and inferior years later.

According to Crisis Text Line (2018), emotional abuse is verbal abuse used to manipulate and control a person without using physical force. There is an imbalance of power in the relationship that can be seen; rejection, isolation, terrorizing, ignoring, and corruption (Crisis Text Line, 2018). Domestic violence is defined as intentional harm against a partner. It can be physical, financial, emotional or verbal, which can be experienced through stalking, blaming, hurting, humiliation, or isolation from family and friends (The National Child Traumatic Stress Network, n.d.). Carlson and Dalenberg (2000), states trauma could be a drastic event such as involving death or injury, a person has to have imminent fear of an injury or death. Medical trauma is defined as psychological or physiological pain. It can be a single episode or an on-going circumstance that results from pain, serious illness, medical procedures, or invasive treatments (The National Child Traumatic Stress Network, n.d.). Natural disaster is an event that displaces people or property, has economic hardships, loss of support and even death. These are experienced with hurricanes, tornados, wildfires, floods or any other extreme weather event (The National Child Traumatic Stress Network, n.d.). Carlson and Dalenberg (2000), describe losing

one's home to a flood is considered a traumatic event, as it produces fear, helplessness, and loss. Finally, there is terrorism violence, which can be foreign or domestic acts of terrorism. It can take the form of a mass shooting, bombing or any other act of terrorism. These acts can result in physical trauma, emotional trauma and traumatic grief (The National Child Traumatic Stress Network, n.d.).

*Diagnosis of Post Traumatic Stress Disorder (PTSD).* According to the American Psychiatric Associations (2013) and Diagnostic and Statistical Manual of Mental Disorders, PTSD is in the Trauma-and-Stressor-Related Disorders. A person with PTSD must meet the following criteria:

Criterion A: stressor (one required)

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s): Direct exposure, witnessing the trauma or learning that a relative or close friend was exposed to a trauma or indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics);

Criterion B: intrusion symptoms (one required)

The traumatic event is persistently re-experienced in the following way(s): Unwanted upsetting memories, nightmares, flashbacks, emotional distress after exposure to traumatic reminders, physical reactivity after exposure to traumatic reminders;

Criterion C: avoidance (one required)

Avoidance of trauma-related stimuli after the trauma, in the following way(s): Trauma-related thoughts or feelings or trauma-related external reminders.

Criterion D: negative alterations in cognitions and mood (two required)

Negative thoughts or feelings that began or worsened after the trauma, in the following way(s): Inability to recall key features of the trauma, overly negative thoughts and assumptions about oneself or the world, exaggerated blame of self or others for causing the trauma, negative affect, decreased interest in activities, feeling isolated and difficulty experiencing positive affect.

Criterion E: alterations in arousal and reactivity

Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s): Irritability or aggression, risky or destructive behavior, hypervigilance, heightened startle reaction, difficulty concentrating or difficulty sleeping; Additionally, these symptoms must last for more than one month and show functional significance such as creating distress or functional impairment (e.g., social, occupational). Symptoms cannot be attributable to medication, substance use or other illness. (American Psychiatric Association, 2013, p. 308).

## ***Effects of Trauma***

*Effects on the Brain.* Trauma impacts the brain's development and function. According to Bremner (2006), traumatic stress affects the amygdala, hippocampus and prefrontal cortex. The stress caused by trauma can have long lasting effects on the brain. Bremner (2006) states there are signs of increased cortisol and norepinephrine levels in the brain of patients suffering from Post-Traumatic Stress Disorder (PTSD). Cortisol and norepinephrine both play an important part in the brain's reaction to stress and memory. Per Maguire, Intraub, and Mullally (2016) the hippocampus is associated with memory and spatial cognition. They discuss what the hippocampus does, continue to research what role the hippocampus plays, and they look at

bilateral hippocampal damage. Bremmer (2006) also discusses memory loss and verbal declarative memory, due to PTSD.

**Treatment of Post-Traumatic Stress Disorder**

Symptoms of PTSD have been around since the early ages, although it was not considered a mental disorder until 1980, when it was officially added to the third edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association (Friedman, 2018). PTSD is unique in the mental health field due to the necessity of there being a traumatic stressor from an outside source. Symptoms of PTSD are subjective for each person, as each person processes traumatic events, emotionally and cognitively, differently (Friedman, 2018). Friedman (2018) states PTSD has gone through criteria revisions in the past two DSM's.

According to Lu et al. (2009), PTSD does have valid treatment options as it has been studied for the past 25 years. Scher, Suvak, and Resick (2017), suggest identifying traumatic cognitions are one of the most important parts treating PTSD. They state research has focused on psychotherapeutic treatments for PTSD have fixated on identification and alteration of maladaptive cognitions. Their study focuses on using cognitive processing theory, which is close to information processing theory (Scher, Suvak, & Resick, 2017). Throughout their study, there is discussion of using emotional processing theory, eye movement desensitization and processing, and cognitive-behavioral therapy to treat PTSD. Scher, Suvak and Resick suggest if theories actively use cognitive change in treatment of PTSD, there is a higher likelihood the maladaptive thoughts will not return. Baker, Metcalf, Varker, and O'Donnell (2018), discuss current treatment guidelines for PTSD include, Prolonged Exposure, Cognitive Processing Therapy, and EMDR. They discuss using non-verbal alternative therapies to treat PTSD. Such as music, dance/movement, or drama therapy. Baker, Metcalf, Varker, and O'Donnell (2018), state

since the 1970's creative art therapies have been used to treat trauma. It is stated that even though creative therapies have been used to treat trauma for many years, there is not enough studies to prove it is helpful. More research is needed on the use of non-verbal therapies to treat PTSD.

As trauma can be difficult to put into words, utilizing aspects of play therapy to express the trauma, while also using EMDR's bilateral stimulation to engage the brain in processing the information being played out, could help many clients process their trauma safely. While there is little research on the integration of Play Therapy and EMDR, both will be discussed for their therapeutic attributes, and then integrated as a recommendation to treat children with PTSD.

**Play Therapy**

Each theory has something it brings into the counseling environment that helps client's process their trauma. Play therapy is a theory used mostly with children. It addresses many psychological problems, including trauma. Play therapy is a way for children to express themselves without using words (Landreth & Bratton, 1999). The Association for Play Therapy (n.d.) states play therapy is a systematic model used in an interpersonal process to help with psychological difficulties. Play is a universal way of communicating for children. Their worlds are made during play and there is no need for words, because they are playing out their experiences and feelings (Landreth & Bratton).

Gaskill and Perry (2014) note that play therapy has been around since the age of Plato. They state trauma does have a negative impact on the brain. It is discussed how trauma can affect the somatosensory and cerebromodulatory systems (Gaskill & Perry (2014). According to Gaskill and Perry (2014) trauma compromises the physiological, motor, emotional, social and cognitive domains. According to Kestly (2016), play therapy is connected to the autonomic nervous system.

It discusses the high and low arousal state of the nervous system. The nervous system then activates the play system if there is no danger perceived. Kestly (2016) discussed how high arousal can incite fight, flight, or freeze and how it is a positive response as it build resilience and teaches the body how to manage a high arousal state.

According to Lin and Bratton (2015) play therapy is an empirically supported counseling technique that bridges the gap between abstract thinking and concrete thinking. Play is an essential part of childhood and is a universal way of expression. Play therapy is first eluded to by Anna Freud in 1928, Margaret Lowenfeld 1935, and Melanie Klein 1961, suggesting unprompted play can communicate unconscious thoughts and emotions (British Association of Play Therapists, 2014). Play therapy is best known for working with kids, but play therapy can be used with all ages (Association for Play Therapy, n.d.), because it is a form of communication that is universal at all ages. Play will change with age, but it will still allow the client to express their thoughts, feelings and experiences.

In understanding play therapy, there are two different approaches that can be used: directive or non-directive play. According to Bratton, Ray, and Rhine (2005), research suggests non-directive play therapy appears more effective then directive play therapy. Directive play therapy is a structured technique that works on symptom relief and teaching skills (DelPo & Frick, 1988). Directive play therapists go into session with a specific plan, designed to meet specific goals, and they have a rationale for using a chosen activity (LeBlanc & Ritchie, 2001; Ryan & Needham, 2001). In non-directive play therapy, the counselor encourages the client to choose what they would like to play with and how they play. Robinson (2011), discussed Carl Rogers being the father of client-centered counseling, which is a non-directive, humanistic approach to counseling. It is states having Rogers core conditions: two people being in

psychological contact, therapist congruence, unconditional positive regard, client vulnerability, and empathetic understanding, which can show positive outcomes in non-directive play therapy. Taking a non-directive approach in play therapy means having a strong therapeutic alliance that reveals the therapist's congruence, acceptance, and empathy of what is being play (Robinson, 2011). Robinson (2011), suggests the therapeutic alliance is the heart of the process and taking a non-directive approach will build the strongest alliance. Ryan (1999), suggest non-directive play therapy allows children the freedom to determine content, insight, and actions in the play room. It states the client instigates the therapeutic change for themselves and does not require the counselor to intervene or interpret the play.

Olson-Morrison (2017) suggests using play therapy as an integrative approach while working with complex trauma in adults. Play therapy, as an approach for working with trauma, gives the person an avenue to express their trauma experience in a safe and controlled environment. Cloitre et al. (2009) discusses using play therapy with trauma and how it effects the neurobiological and developmental functioning of the brain. If a person is traumatized as a child but never processes it, the trauma can persist in the brain at a childhood level. Ryan, Lane, Powers (2017), discuss the impact of early childhood trauma and stress on the neurobiological development of children. They discuss play as a healing, self-regulating and communication tool.

*Art Therapy*. Contemporary Art Therapy, which is an extension of play therapy, is relatively new to the counseling world. Art has been around for over 40,000 years (Art Therapy Journal, n.d.) and has widely been used as a tool for communicating thoughts, ideas, symbols, religion and self-expression. Art therapy is the blending of discipline and psychology to make a unique new healing phenomenon (Malchiodi, 2003). Art therapy can be used to treat people of all ages, with all different kinds of diagnoses, whether that be emotional, cognitive or physical

(American Art Therapy Association, 2010). Art therapy did not get its real start until the 1940's, mostly in Europe and America (Art Therapy Journal, n.d.).

Utilizing art therapy with trauma clients is another way to express what cannot be put into words. Using art therapy with trauma clients can give them a way to expel, release, communicate and understand the pent-up emotion in themselves that may be too hard or complicated to put into words (Collie, Backos, Malchiodi, & Spiegel, 2006). According to Talwar (2007), using art therapy as a way to address the non-verbal core of a traumatic event can be a way for the client to relieve themselves of the memory.

*Sand Tray Approach*. Another approach to working with trauma, is through a sand tray. Sand tray therapy is a technique used along with traditional "talk" therapy. It utilizes a sand box, imagination, miniature objects and water (Sandplay Therapists of America, 2017). It is a theory that illuminates inner thought, feelings and emotions, with the use of a symbolic world, all contained in a safe box (Sandplay Therapists of American, 2017). Per Webber and Mascari (2008), sand tray therapy is recognized as an effective tool to heal trauma. It is a non-verbal experience that establishes safety, reconstructs their story and restores community connections.

**Eye Movement Desensitization and Reprocessing (EMDR)**

Eye Movement Desensitization and Reprocessing (Shapiro, 1989) is a therapy that has become more popular in the last few years. It is an evidence-based approach, used to treat trauma, and was developed by Dr. Francine Shapiro in 1987 (Shapiro). According to EMDR International Association (2018), EMDR has been extensively researched and has a standard protocol to be used when treating a client. It pulls elements from other treatment approaches to make it effective when treating trauma. EMDR was introduced in 1989 as a treatment for post-traumatic stress disorder (Shapiro). They state evaluative research proposes EMDR could be an

even more effective treatment than exposure therapy. Rogers and Silvers (2002), report EMDR is a client centered approach that focuses on a distressing moment while trying to change the picture, affect, cognition and physical sensations associated with the traumatic time.

EMDR is made up of an 8-phase approach that is three-pronged (Shapiro, 1989). The 8 stages are; history, preparation, assessment, desensitization, installation, body scan, closure and reassessment (p. 3). The three prongs are past, present and future. These stages do not have to been done in a specific order every time. EMDR works to recode maladaptive memories or experiences. A primary aspect of EMDR is the use of bilateral stimulation. Bilateral stimulation could be eye movements, audio tones or tactile stimulation (Becker & Tinker, 1995). Another aspect of EMDR, when working through trauma, is having a safe place for the client to go. A safe place is a place the client can go inside themselves to relax and feel safe. A safe place should have walls, encompass senses and have a comforter (PESI INC., 2017). In utilizing EMDR there has to be a target memory, a negative cognition and a positive cognition. The client works through desensitizing the negative cognition, installing the positive cognition, then scanning their body tension (Becker & Tinker, 1995). EMDR can be practiced with youth, all the way to end of life cares for adults. EMDR can be modified to fit each age range (PESI INC., 2017).

EMDR works by retraining the brain in how it reacts to the traumatic memory. According to Personal Transformation Institute (n.d.), EMDR relocates incorrectly stored memories in the brain to a more functional part of the brain. They state due to the brain incorrectly storing the traumatic memories, it makes the memories feel present and have unrelated stimuli trigger their memories (Personal Transformation Institute, n.d.).

EMDR is known for being evidence based in helping to reprocess traumatic memories. Rasolkhani-Kalhorn and Harper (2006) discuss the synapses in the limbic system as a key component in fear memory formation. Using a mechanism to induce a low frequency stimulation, modifies the synapses of the fear the memory traces. This is a main process in EMDR and they theorized that is one of the main biological factors in what makes EMDR work (Rasolkhani-Kalhorn and Harper, 2006). According to the American Psychological Association (2019) the clinical practice guideline for the treatment of posttraumatic stress disorder, EMDR focuses directly on one memory and is intended to restore that specific memory. Other therapies look to address the emotions, thoughts and responses to trauma instead of restoring the memory. EMDR differs from other therapies because it looks at one specific memory at a time, using bilateral stimulation to reprocess and restore the traumatic memory (American Psychological Association, 2019). EMDR is used to reduce the vividness and emotional connotation with each traumatic memory (American Psychological Association, 2019).

**Integration of Play Therapy and EMDR**

Play therapy and EMDR are both evidence-based practices for working with trauma. They both have been successful in treating clients who have been through a traumatic experience. I am proposing the integration of both therapies, as a new integrated treatment, to work with clients who have experienced traumatic events. This could be even more successful than using them independently. There is limited research on the integration of EMDR and play therapy. That is one of the limitations of this review.

Both play therapy and EMDR are evidence-based methods that can be used when treating trauma. Beckley-Forest (2015), discusses her use of play therapy and EMDR to treat children who have experienced trauma. In this case study, Beckley-Forest (2015), used play therapy and

EMDR to treat a young girl using theratappers while the child is playing out the traumatic experience in her own way. Also used was a lifebook, which involves drawing out the client's life on a big role of paper, to integrate assessment, de-sensitization, and reprocessing from EMDR (Beckley-Forset, 2015). By integrating these two therapies, Beckley-Forset (2015), found the child was able to process her trauma in a non-directive and safe environment. In Beckley-Forset (2015) case study, the young girl came into therapy for a car accident, however using EMDR and play therapy together she found the child was struggling with her adoption. In Schmidt (1999), she discussed the integration of EMDR, ego state therapy, and art therapy. Beckly-Forset (2015), stated having clients draw their positive and deficiency aspect, gives them a way to stay present in the session. As they progress through the EMDR protocol, they may redraw their pictures to update their positive or deficiency aspects (Schmidt, 1999).

**Counselor Role in Trauma Work**

The role of a counselor is to provide a safe and comfortable environment for the client to be able to share their thoughts and needs. This is especially true when working with clients who had a traumatic experience. Building the therapeutic alliance and trust between the client and counselor are one of first steps in the counselor role. They need to provide an emotionally and physically safe, confidential and comforting environment (Play Therapy International, 2018). In addition, they need to find ways to provide therapy in developmentally appropriate ways for children and adolescents. Play therapy allows children to communicate through play. The counselor then can reflect observations seen in the clients play (Play Therapy International, 2018). With indirect play therapy, at times just being in the room and listening to the client is all that is needed for therapeutic interaction. With direct play therapy, the counselor is more

structured and direct in the play. The counselor may choose what to play and may help with specific coping strategies or other forms of skill development within the play.

The counselor's role in EMDR is a directive approach. The counselor walks the client through all 8 stages. In EMDR the therapist must help the client clarify each specific memory. They are using scaling technique to measure where the client is at with each memory. In EMDR the counselor is asking questions, clarifying words and listening to what the client is saying. With younger clients, EMDR is directive. However, it may not be in words, but in how they directly play with the client.

Therefore, together these therapies represent a unique avenue for clients to process their trauma. Integrating EMDR and play therapy opens up opportunities for the therapist to utilize directive and non-directive approaches with the client. Play therapy as a theory emphasizing the use of non-verbal communication and EMDR, which utilizes a more directive approach, the two compliment each other in guiding the client through its protocols. When integrating these theories, it gives the therapist flexibility and mobility in how and when to use pieces of each approach (Beckley-Forset, 2015). Beckley-Forset (2015), discussed the integration of play therapy into the preparations stage of EMDR. Giving the client the freedom to be client-centered in play build the therapeutic relationship. Schimdt (1999) discover when using an integrated approach with EMDR and art therapy, it provides a clearer picture of the client's personal view of their trauma.

There is limited research on the integration of these two theories. More research would be needed to understand how the interaction of these theories progress with PTSD treatment. Further investigation on the future outlook and success of these integrated treatment is required.

## Conclusion

Trauma comes in all forms; emotional, physical or mental and can affect each person differently. According to SAMHSA-HRSA (n.d), 61 percent of males and 51 percent of females experience some kind of trauma in their lifetime. They also note that 90 percent of client's who seek behavioral help have been exposed to a traumatic experience. Working through that trauma is a difficult task and takes a skilled clinician to avoid retriggering a client in a damaging way when discussing the trauma.

Play therapy is an evidence-based practice, that allows children to play out their experiences in a safe environment helps them process and express their thoughts and emotions. Per Beckley-Forest (2015), play therapy develops emotional safety, promotes physiological soothing, emotional modulation, allows for slow exposure to the traumatic experience and makes sense to the child in light of their trauma. Play therapy is more than 'just playing', and also could include art, music and/or a sand tray therapies.

EMDR is an evidence-based practice used to treat trauma in all ages. It uses an 8-pronged protocol to reprocess specific memories in the brain and uses bilateral stimulation when processing the traumatic memory.

Integrating these two models could be useful for all ages. The integration of these could be beneficial, because it uses play as a way of communication when words can be hard to find. Having the client draw their experience, lay it out in a sand tray, or play it out while utilizing some form of bilateral stimulation, could help process their memory in a more comfortable manner. Play therapy and EMDR require the clinician to be flexible and able to navigate trauma through both processes. While there is limited research on the integration of Play Therapy and EMDR in working with trauma clients, it is the hope of this author that this discussion will

compel clinicians and researchers to try this integration and conduct research on its' effectiveness. Using these techniques together will take time to learn and will need considerations of how to use them individually as well. Careful thought and planning will be needed on how to integrate them in a therapeutic manner and ethical consent of the client will needed when trying unresearched methods. Nonetheless, integration of play therapy and EMDR shows promise for the treatment of trauma in children.

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