Body Psychotherapy in the Playroom

A Somatic Approach to Working with Child Clients

Jennifer L. Taylor

ABSTRACT

This paper proposes a theoretical model of play therapy that blends developmental neurobiology perspectives with tenets of body psychotherapy. The author suggests that the current application of neurodevelopmental principles in play therapy can be bolstered by somatic interventions that foster integration between the body and mind of the developing child. The topics of regulation, attunement, and interoception are explored from a somatic lens, and therapeutic applications are considered. This paper sets forth an integrative, trans-theoretical approach of incorporating body psychotherapy principles in the playroom.

Keywords: body psychotherapy, play therapy, somatic psychology, regulation, attunement, interoception

Received: 08.04.2019
Revised: 20.05.2021
Accepted: 26.05.2021

International Body Psychotherapy Journal
The Art and Science of Somatic Praxis
Volume 20, Number 1,
Spring/Summer 2021, pp. 84-95

ISSN 2169-4745 Printing, ISSN 2168-1279 Online

This paper explores a theoretical model that melds the disciplines of play therapy and body psychotherapy. The topics of regulation, attunement, and interoception will be explored from a somatic lens, underpinned by the current literature in attachment and developmental neurobiology. While many varying models of play therapy exist, this paper offers an integrative, trans-theoretical approach of incorporating body psychotherapy principles in the playroom.

Literature Review

Contending with chronic stress, neglect, abuse, or trauma is detrimental to the physical and emotional health of all beings, but it is especially deleterious to the brain and nervous system of a developing child (Perry, 2006; Schore, 2009; van der Kolk, 2015). Adverse experiences in early infancy and childhood can have lifelong impacts on the emotional, physical, neurological, and behavioral health and wellbeing of the child (Kain & Terrell, 2018; Ogden, Pain, & Fisher, 2006b; van der Kolk, 2015). It is estimated that 74% of individuals who contend with mental health issues in childhood will continue to cope with similar concerns in adulthood (Leggett & Boswell, 2017). Thus, addressing childhood mental health concerns is important not only for the child, but for the adult they will become, and ultimately carries larger societal implications.

> ***Children operate from a sensorimotor, bottom-up, emotional system, and are not yet able to effectively utilize their higher cortical functioning and cognitive reasoning capacities.***

It is imperative that therapeutic interventions are developmentally appropriate and match the physiological and emotional needs of the child in order to be successful (Perry, 2006). Play is a basic and essential component of childhood and development; thus, play therapy offers a developmentally appropriate modality when working with children (Dion, 2018; Leggett & Boswell, 2017).

Play Therapy: An Overview

Play is the way in which children learn to construct their world, gain social skills, develop expressive language and emotional capacities, and cope with their inner feelings and external surroundings. Play therapy is an especially appropriate approach to working with children because it is how children inherently communicate their inner worlds through the projective process of play. Often, more can be deduced by how a child plays than through the words they use, as language is not yet fully developed and emotions are not easily articulated (Lin, 2015).

The Association for Play Therapy (2014) broadly defines play therapy as the ways in which trained clinicians employ the therapeutic powers of play to help child clients work through and resolve psychological, social, and emotional difficulties in order to achieve optimal growth and development. There exist four main theoretical models of play therapy: psychoanalytic, humanistic, behavioral, and developmental (Gil, 1998). Each model has its own theory on how best to approach play in a therapeutic context. Play therapists typically fall into directive or non-directive orientations, differing in opinion on how involved the therapist should be in setting up, participating, intervening, and creating meaning during play. While empirical evidence for the effectiveness of play therapy interventions is notably lacking, a 2005 meta-analysis showed favorable treatment outcomes for a more humanistic orientation to play therapy as opposed to non-humanistic models (Bratton, Ray, Rhine, & Jones, 2005).

Neurodevelopment and the Nervous System at a Glance

Garnering a basic understanding of how the brain and nervous system process information and respond to real or perceived threat helps clinicians understand what is going on in the mind and body of their client. This understanding allows clinicians to tailor their approaches in ways that meet the child's needs in real time (Perry, 2006). Thus, acquiring an operative appreciation of neurodevelopment and the nervous system can help the somatically oriented play therapist target interventions in a way that accesses the neural networks responsible for emotional regulation, attunement to self and other, and somatic awareness of self in a developmentally appropriate way.

A neurodevelopmental approach. The brain is structured in a hierarchical manner that moves from primitive (brainstem) to complex (neocortex). All sensory information coming from both inside and outside the body must first enter lower brain regions (Perry, 2006). The brainstem, also referred to as the body brain, is the only part of the brain fully developed at birth, and is responsible for basic survival functions (Badenoch, 2008; Cozolino, 2006; Ogden & Fisher, 2015). The brainstem also serves as a relay station between body and brain, interpreting sensory information and regulating internal physiological cues, and plays an important role in the interoceptive process – the ability to feel and know what one is feeling – all important considerations for the somatic play therapist. The limbic system is responsible for affective knowing and emotional responses and monitors the environment for danger and real or perceived threat. Lastly, the neocortex allows an individual to think, problem-solve, engage in abstract thought, and offers declarative knowledge; importantly, this area of the brain does not reach full development until the mid-twenties (Siegel & Bryson, 2016; van der Kolk, 2014). However, optimal functioning of the cortex is dependent upon the integration and regulation of lower cortical centers (Badenoch, 2008; Kestly, 2015; Perry, 2006). Thus, play therapists must learn to work with each of the three main brain centers: the body brain (brainstem), the emotional brain (limbic system), and the thinking brain (cortex).

Understanding the nervous system. As Kestly (2015) elucidates, it is more appropriate to refer to the brain as an "embodied brain," as research makes it evident that brain functions are intricately interconnected and distributed throughout the body, with information processing and signaling moving in both a top-down (brain to body) and bottom-up (body to brain) fashion (Badenoch, 2010; Cozolino; 2010). The nervous system allows the brain and body to communicate in this bidirectional manner.

Developed by Porges (2011), the polyvagal theory offers an expounded explanation of the autonomic nervous system responsible for an individual's fight/flight/freeze/collapse response in the face of threat. Porges (2011) coined the term *neuroception*, which refers to the process by which neural circuits evaluate threat or safety. Neuroception of safety is the somatic felt sense that occurs when an individual perceives the environment to be safe and secure. When safety is established, humans can engage in ways that foster social connection and positive attachment, via what Porges (2011) refers to as the social engagement system. Infants, children, and adults alike will shut down this social engagement system in the face of threat. When frightened, subcortical brain regions take over and physical survival is prioritized, mobilizing the flight/fright/freeze or collapse response (Ogden & Fisher, 2015; Porges, 2011). If

... optimal functioning of the cortex is dependent upon the integration and regulation of lower cortical centers. Thus, play therapists must learn to work with each of the three main brain centers: the body brain (brainstem), the emotional brain (limbic system), and the thinking brain (cortex).

the individual perceives they can do something about the threat, the sympathetic nervous system will be activated as one prepares to fight or run from danger (e.g., the child that is brought to therapy for aggressive behaviors or anxiety). If, however, the threat seems insurmountable, the collapse response will be initiated, and symptoms of hypoarousal will be apparent (e.g., the depressed child client). Please refer to Figure 1 for an overview of symptoms of hyperarousal and hypoarousal, as tracking these cues will be important for the somatic therapist in the playroom.

Body Psychotherapy

Traditional approaches to mental health have focused on cognitive models of therapy, ignoring the body and its somatosensory experiences (Aposhyan, 2004; Kurtz, 2007; Ogden et al., 2006b). Children operate from a sensorimotor, bottom-up, emotional system, and are not yet able to effectively utilize their higher cortical functioning and cognitive reasoning capacities (Ogden & Minton 2000; Perry, 2006; Siegel & Bryson, 2016). Thus, early traumas and non-integrated stressors are primarily expressed and experienced through the body, not through words or cognitive understanding of events (Levine, 2010; Ogden et al., 2006a; van der Kolk, 2015). It is this understanding that underpins the theoretical rationalization for using a somatic approach in play therapy.

The somatic body psychotherapist facilitates body awareness and sensations in the client, helping the individual to slowly experience feelings and bodily cues that might have been previously heightened, cut off, or denied (Ogden et al., 2006). Body psychotherapists do not eschew the importance of cognition, but rather seek to include the implicit, relational ways of being and knowing that are hallmarks of embodied experience (Levine, 2010; Ogden et al., 2006a). The author has, and will, utilize the terms somatic and body psychotherapy interchangeably throughout this paper in reference to this body-centered approach that purports health is ultimately an individual's integration of their somatic, emotional, and cognitive self.

Attunement

Attachment and attunement. Attachment is the emotional bond between the infant and primary caregiver/s that shape the child's developing brain and nervous system, and has lasting impact on an individual's visceral, somatic, and non-verbal sense of self (Cozolino, 2010; Schore, 2009). The early child-caregiver relationship is a dance of bodies and right-brain to right-brain attunement (van der Kolk, 2014). Through attuned caregiving, a parent can mirror and help an infant regulate their levels of emotional arousal, facilitate the infant's capacity to develop their own self-regulatory capacities, and come back to a state of homeostasis in the body. The emerging sense of self is first and foremost a body sense, in which an infant feels and communicates via sensations, emotions, and movement (Ogden et al., 2006b). It is this early implicit knowing, and its subsequent influence on patterning, beliefs, and emotional states, that are of interest to the body psychotherapist when working with child clients.

Van der Kolk (2014) states that children who do not receive physical attunement from caregivers are liable to shut down direct feedback from the body, impacting their ability to perceive somatic sensations later in life. Moreover, early attachment traumas impact the developing oribitofrontal cortex, a part of the brain that governs the unconscious processing of social and affective information, regulation of bodily states, and the ability to cope with stress and emotion (Ogden et al., 2006).

It is important to highlight the reciprocity involved in this attuned relationship, noting that both client and therapist impact one another (Dion & Gray. 2014). To truly be attuned to a client's internal and emotional world, it is necessary for the therapist to be open to, aware of, and in communication with their own somatic sensations (Badenoch, 2008; Dion & Gray, 2014). Thus, to foster this resonant relationship with a client, the somatically oriented therapist must work to become an embodied practitioner. It is through this nonverbal, attuned therapeutic relationship that a child can come to know and understand their emotional world, which subsequently impacts their ability to self-regulate through states of emotional intensity (Dion, 2018; Schore, 2012; Wallin, 2007).

Regulation

Regulation and co-regulation. Regulation refers to an individual's capacity to manage their emotional states (Kain & Terrell, 2018). It has been well-documented that regulation is a learned process. Parents play a critical role in teaching children how to soothe themselves in the midst of emotional intensity. Children develop this skill, either effectively or ineffectively, by observing and mirroring caregivers' responses to dysregulation, which in turn impacts how successfully they will regulate their own emotions and cope with stress, even as adults (Kain & Terrell, 2018; Siegel & Bryson, 2016). This process of helping a child manage emotions and find their way back to a place of optimal arousal is known as co-regulation. Co-regulation is the back-and-forth dance between adult and child that is inherently somatic (Kain and Terrell, 2018). Regulation is

... the somatically oriented therapist must work to become an embodied practitioner. It is through this nonverbal, attuned therapeutic relationship that a child can come to know and understand their emotional world...

important in the therapeutic context because cortical functioning goes offline during moments of very high or low arousal. Thus, attempting to talk or reason with a child when they are operating from subcortical regions will be largely ineffective. The somatic play therapist works to help children titrate their somatic and affective experience in ways that keeps the cortex "online."

Feel it to heal it takes the naming of emotional states a step further by proposing the therapist embodies the emotional state in their own body, mirroring back to the child what the emotion looks like in an embodied sense.

Fostering Somatic Awareness

Interoception. Interoception refers to an individual's ability to detect internal sensations occurring in the body such as body temperature, heart rate, hunger, and other internal sensorial cues (Murphy et al., 2017). Porges (2011) refers to interoception as the infant's sixth sense. It has been proposed that atypical interoception plays a causal role in the development of psychiatric disorders, with clients demonstrating a reduced ability to read cues from the body on the one hand, and hyperawareness to interoceptive signals on the other (Murphy et al., 2017). The role of the somatic therapist is to help clients become aware of, name, and appropriately respond to their interoceptive experience. Increased interoceptive and somatic awareness involves integration of multiple brain regions, and thus can assist in promoting both lateral and vertical connectedness of neural regions – helping children become aware of their sensations (bottom-up processing) and put words to their experience (top-down processing).

BODY PSYCHOTHERAPY IN THE PLAYROOM: A THEORETICAL MODEL

Language and words are cognitive in nature, and thus are not the natural communication style of children governed by a kinesthetic way of being in the world. Therefore, learning to engage with children on a nonverbal level is essential for play therapists, and provides the perfect platform to integrate somatic work. Many existing play therapy models recognize the importance of attunement, regulation, and somatic interventions in the playroom, though few come from a body psychotherapy orientation. The following framework is inspired by the tenets of Synergetic Play Therapy and the teachings of its creator, Lisa Dion. For a graphic representation of this theoretical model, please refer to Figure 1.

Calming the Limbic System: Attuning Through Mirroring

Understanding how nervous system cues manifest in the playroom has salient implications for the somatic therapist as they track the micro and macro movements of their clients, and use this information to guide their therapeutic approach. It is the somatic therapist's responsibility to attend not only to what is said by the child, but also to the nonverbal communication of their body and their play. In this way, the somatic therapist gains insights into what the child client is unable to express consciously and mirrors it back to them in ways that can increase awareness and promote integration.

Naming emotional and somatic experience. Attunement requires connecting with the child and their emotional experience. Siegel and Bryson (2016) state "connect first, and solve second" (p. 36). The somatic therapist tracks the nervous system cues of the client, attunes to the setup and emotional resonance of the play, and reflects back an emotional understanding of what the child is communicating. This is a crucial first step, as this model proposes that emotional attunement must occur prior to any intervention. If the child is in a state of hypo- or hyperarousal, lower brain regions can become flooded with sensations and emotions. The "name it to tame it" strategy (Siegel and Bryson, 2016) serves a few functions. It has a regulatory affect in and of itself by naming and acknowledging what is occurring, which can help calm the amygdala's alarm bell (Dion, 2018). It also brings higher cortical functioning online, helping children make sense of their emotions and sensations, and put words to their experience.

Attuning through the body. Building off the name it to tame it strategy, this author proposes a novel therapeutic intervention dubbed "feel it to heal it". Feel it to heal it takes the naming of emotional states a step further by proposing the therapist embodies the emotional state in their own body, mirroring back to the child what the emotion looks like in an embodied sense. As the literature states, observation is one of the central ways children come to understand the world around them, and ultimately themselves (Dion, 2018). Wallin (2007) speaks to this experience as affect attunement, a type of collaborative communication that is emotionally congruent and contingent on what is happening in the moment. Embodied mirroring allows the child to realize their own emotional and sensorial states can be allowed, recognized, and shared by another. Mirroring, or posture sharing, generates a feeling of being with a client in a way that increases communication, a sense of being seen and felt, and builds rapport. It is important to note that mirroring is less about copying a posture exactly, and much more about resonating with the emotionality behind the embodiment, which sets the stage for affect regulation, discussed next.

Talking to the brainstem: regulating with breath, rhythm, and movement. Most children are brought to therapy due to behavioral concerns. It takes a perception shift to realize that all behavior is just an attempt to regulate the nervous system and offers communication about what the child is experiencing internally. If the therapist can hold this in mind, it is easier to understand and befriend the anxious, aggressive, or shutdown behaviors of the child, and help model new ways of coping with somatic and affective experiences.

It is in an environment of safety that one has access to their cognitive resources and social engagement system. Therapists cannot help a child access their higher cognitive brain functions if their lower brain regions are sounding the alarm. Thus, regulation of these subcortical structures must be a priority in the playroom. Regulation helps both child and therapist to titrate, befriend, and move through emotional intensity. The brainstem serves as the epicenter for the regulation of arousal (Levine, 2010). This interactive psychobiological regulation is nonverbal in nature, as the brainstem communicates and responds to movement, rhythm, and breath – not words. Regulation is used to allow both therapist and client to move towards the emotional and somatosensory experience together, as opposed to regulating out of any particular nervous system state (Dion, 2018). In this way, the therapist helps the child client to stay with emotion and sensation, thereby expanding their window of tolerance.

The somatic body psychotherapist. As regulation is primarily a somatic interaction, clinicians need to develop their own bodily awareness and regulation capabilities. If therapists are overwhelmed by their affective and somatic experience, or conversely shut off from their implicit bodily knowing, they will be less effective in allowing emotional intensity in their clients. Regulation allows both the therapist and client to develop a relationship with a previously shut off or unconscious emotion, to feel it more fully in their body, and to be able to stay present in the experience. This author encourages therapists to study their own nervous system patterns by referring to Figure 1. Lastly, dysregulation should be welcome in the playroom, as this is where, in real time, therapists get to meet the client and demonstrate a new and novel way of being. What the therapist disallows in themselves, they will often cut off in their clients, as an unconscious attempt to manage their own nervous system. Thus, the therapist must learn to self-regulate so that they can be available to co-regulate with their clients.

Feel it to heal it: regulating through rhythm and movement. As Siegel and Bryson (2016) explicate, bodily movement has a direct impact on brain chemistry. When a child is dysregulated and has lost touch with their cortex, the fastest way to help them come back into balance is through movement. This is where having an appreciation of nervous system states can provide insights and guide a clinician in how best to approach movement with a client (Figures 1 and 2). A therapist will choose a movement intervention based on whether the client is in hyper-, hypo-, or optimal arousal, and will then model regulation (through a non-directive approach) or propose a movement intervention (through a directive approach). As the therapist and client engage in rhythmic movement, they allow themselves to feel the emotions and accompanying sensations in their body, creating a new implicit understanding that such intensity is temporary and can be both felt and sequenced.

Breath. Breath is an important tool in the playroom, as it is the quickest way to alter nervous system states (Levine, 2010). Many body psychotherapists incorporate breath work in their practice, including but not limited to calming the activated client, charging the nervous system for emotional and physical processing, or as a resource for regulation. Incorporating breath work, either in a non-directive manner via modeling and naming, or directly through purposeful interventions, can be a powerful intervention for the somatic play therapist. The type of breath work used will be dependent on whether the child is exhibiting signs of hyper- or hypoarousal. Children in a state of hyperaroused activation will be best served by taking long, deep, diaphragmatic breaths that focus on extending exhales as this will serve to calm sympathetic arousal. In contrast, children exhibiting hypoarousal symptoms can wake up the parasympathetic nervous system by taking quick, short breaths. Therapists can model these varying breathing patterns in their own body non-verbally, mirroring to the child ways of regulating. One directive approach to breath work is incorporating the use of bubbles. Children needing to calm their activation can be instructed to blow the largest, biggest bubble they can. This will necessitate the child to slow their breath and use their exhalation mindfully. The hypoaroused child can be invited to blow as many bubbles as possible, as quickly as possible, thereby bringing energy back into the system. Body psychotherapists learn to watch and assess their client's breathing patterns, noting how the child's breath manifests both under stress and when relaxed. In turn, this knowledge will inform the breath work interventions the therapist proposes (Caldwell & Victoria, 2011). This section offers only a brief exploration of the use of breath interventions in the playroom. Interested readers are encouraged to learn more about the regulatory capacity of breath and get creative in their interventions in the playroom.

Increasing Interoception

Naming sensations. The somatic therapist helps children recognize internal sensations and provides the child with language to describe what is happening in their bodies. Just as play therapists help children develop a vocabulary for emotions, so too is it important to provide children a lexicon for sensations. Children who operate from a state of chronic hyperarousal often feel a lot of sensation, whereas hypoaroused children might

feel numb or detached from their somatic self. Helping children place mindful, titrated, and guided attention on their body and its somatosensory experience can aid in distinguishing between sensation, emotion, and cognition, and understand how each intimately impact one another.

As interoception involves both higher and lower brain regions, it is important to find interventions that speak to each brain area. Thus, the somatic therapist incorporates both bottom-up and top-down approaches with interventions that are targeted to the regions of the brain responsible for somatosensory processing (brainstem), emotional appraisal (limbic system), and higher-order thinking (cortex). For a directive approach to fostering somatic awareness in a way that promotes integration across brain regions, please see Appendix C: Feel it to heal it: Listening to My Body. This directive helps children to become mindful of their embodied experience and track internal sensations.

The somatically-inclined therapist might ask a child to notice their body with a few prompts: notice your whole body, now notice just your finger. Notice which parts of your body feel loose, notice which feel tight. If those tight shoulders could talk, what might they say? The attached worksheet helps a child to tap into specific sensations and their accompanying emotions, pinpoint where they are feeling the experience in their body, and consider what movement their body might want to take next. Employing the feel it to heal it strategy, the therapist allows the sensation a voice, presence in the body, and a chance to sequence through movement and rhythm. An example of this theoretical approach in action follows.

APPLICATION

The following example draws on observed play themes with child clients, but is primarily fictitious in nature and for illustrative purposes only. Please reference Figure 2 for an illustrative representation of this theoretical model.

Working with Sarah

Sarah is a seven-year-old client with a history of early medical trauma. When Sarah was three years old, she underwent medical procedures that required her to often be immobilized for a series of scans. The following scenario demonstrates the ways in which Sarah plays out her unconscious and implicit memory of her experience. For the sake of demonstration, the projected play in the following scenario is obvious. It is important to note that not all play will be quite so literal, and many times the therapist will not know explicitly what is being played out. Luckily, meaning making is the work of the cortex, whereas the body psychotherapist in the playroom is much more concerned with the nonverbal and implicit felt sense of the child's experience. It is less important to cognitively understand what's transpiring, and much more salient for the therapist to *feel* their way through the play. This is where the science and art of psychotherapy meet.

Tracking the nervous system. Sarah picks up a baby and begins to tie a scarf around the baby's arms, pinning them to its side. Sarah sets the baby down and walks away, leaving the baby alone on the other end of the room. A body-centered therapist would simultaneously begin to track the affective and somatic experience arising in their own body, while also watching the body language of the client, tracking for signs of dysregulation. The therapist tracks Sarah, and notices her breath is short and shallow, her eyes are open wide, and she is exhibiting tension in her upper body. The therapist senses sympathetic activation, and meets the client in the intensity, both verbally and nonverbally (attunement). Before the therapist can help the client sequence this stuck arousal energy, she must first attune to the emotional and somatic experience, help Sarah regulate through the intensity, and engage her interoceptive awareness.

Regulation, attunement, and interoception in action. The somatic therapist is tracking breath, tension patterns, speed of movement, bodily and facial expressions, cadence of speech, eye contact, and pupil dilation, among other nervous system cues. The therapist sees that Sarah is demonstrating signs of hyperarousal and begins to feel it in her own system. Staying present in the play, the therapist begins to use breath and movement to regulate the activation. The therapist takes a few deep, audible breaths as she rocks side to side, engaging the rhythm necessary to calm the brainstem. The therapist then engages both the name it to tame it and feel it to heal it strategies to assist in attunement and regulation, while also naming somatic experiences to cultivate interoceptive awareness. For example, the clinician (rocking side to side) might state: "I'm feeling really nervous right now, I want to help the baby, but don't know how" (regulation/attunement). "If I were the baby, I might feel stuck and confused. I feel hot and prickly in my own body" (modeling interoceptive awareness). Then the therapist models regulation: "I need to take a deep breath," and can offer a directive probe: "I wonder what you think that baby is feeling?". If the therapist believes the client is within their window of tolerance, they can take this a step further and inquire/reflect, "I wonder what is happening in your body right now, Sarah; some tightness in the shoulders huh?" (using interoception to help the client name her felt sense experience). It is unimportant whether or not the client answers this directive. The simple invitation to notice their body and emotions is often enough to spur at least a momentary curiosity in the child as they scan their own internal landscape. There is no right or wrong way to regulate, move, or feel in a play session. The most important aspect in this somatic approach is staying authentic, attuned, regulated, and emotionally connected to the child and to self-as-therapist.

As Sarah progresses in her therapy, she begins to demonstrate an increase in somatic and affective awareness and regulation capabilities. This is evident in her mounting ability to allow, name, and stay connected to self and her somatic and emotional states, either projectively (e.g., "the baby feels scared right now") or self-reflectively (e.g., "my tummy feels swirly," as she takes a deep breath). As Sarah's play progresses, she plays out similar themes, but in novel ways, eventually leading to the sequencing of the previously thwarted survival movement, her inability to move during the scans.

Therapist self-regulation. Further on in her treatment, Sarah transfers her projective experience from the toys to the therapist. Sarah approaches the therapist and tells her she is "under arrest." She cuffs the therapist with the toy handcuffs and directs her to sit on the couch, where she instructs her that she "is not allowed to move." Sarah is now helping the therapist to feel the direct experience of being immobilized.

As play increases in intensity, it is important that the therapist remains regulated and embodied in the experience. If the play scenario is outside the therapist's window of tolerance, they will engage their own nervous system defenses in an attempt to manage the emotional intensity of the play. In this scenario, it could be easy to imagine a dysregulated therapist naming, "I feel stuck; I need to get away!", removing the restraints, prematurely sequencing activation, and shutting down the play. This author proposes that a child needs to be deeply felt and met in the activation first, and then the therapist can regulate the intensity, thereby widening the child's (and perhaps the therapist's) window of tolerance. This example highlights the importance of the therapist doing their own work of staying embodied, developing the skill to track their own nervous system state and window of tolerance, and the ability to remain titrated in the play.

Getting unstuck. Ideally, the therapist uses the aforementioned strategies of breath, movement, and naming/feeling the emotional and somatic experience to stay regulated and attuned with the client, and present in the intensity of the play. The therapist begins to self-regulate while mirroring the intensity in her own body and naming "I feel scared. My chest is tight and I feel fluttery. I'm stuck." The therapist is helping the client to hear, feel, and name what was previously an unconscious and unintegrated experience. As the therapist allows these sensations, emotions, and feeling in herself, she gives permission for Sarah to allow them in herself as well. As the therapist attunes to the emotional and somatic sensations, she begins to use movement, breath, and rhythm to model ways of staying embodied and attached to self in the midst of the intensity.

It may take multiple sessions for things to begin to shift. In an earlier session, the therapist mirrors hyperarousal in the body while stating, "I want to break free. I feel so scared and alone. My chest is hurting. Can I get out now?" to which the client responds with "No. You aren't allowed. You are stuck there." The child needs the therapist to understand the intensity of the initial experience, to feel the helplessness and stuckness in her own system. As Dion (2018) elucidates, play can become stuck or intensity can heighten until an authentic and equivalent response is elicited in the therapist and is allowed expression. In this regard, this model proposes that the child can go only as deep as the therapist is willing to go, an important caveat.

In this example, let's imagine the therapist has an emotionally congruent response to the play scenario. This time, instead of naming the desire to break free (hyperarousal) the therapist connects with the sense of hopelessness and powerlessness that is being evoked by the child (feeling into the hypoarousal), and states, "I feel like I will never get out; part of me feels like giving up," as she mirrors aspects of collapse in her own body through a slumped posture and a heaviness in the upper body and torso. In this moment, the therapist taps into the other side of the nervous system, giving voice to the hypoarousal, and mirroring what it might be like to feel powerless to move (name it to tame it/feel it to heal it). This is important, as a trauma response often carries with it both ventral and dorsal activation and giving authentic voice to both can be necessary for integration to occur (Levine, 2010). This theoretical model proposes that once the entirety of the experience has been felt, named, and co-experienced, the client can then move towards the healing that comes with moving through the intensity, thereby finding integration and empowerment.

Sequencing is a somatic approach to working with trauma, which posits that a previously thwarted survival response (e.g., being unable to engage the fight-or-flight mechanism during a traumatic event) needs allowance to move through the body. In this scenario, sequencing might look like Sarah allowing the doll or therapist to break free of their confines, thus activating the missing defensive response and allowing the body and nervous system to reset (Levine, 2010). The client, having been sufficiently felt, now grants permission for the therapist to break free. The therapist would then shake off the energy in the arms, moving in a way that felt authentically mobilizing in their own system. The therapist can invite the client to move along with her, ask the client what her body would like to do, or co-create a movement sequence together that allows movement back into the body and the arms. Sarah may just witness the therapist and learn new ways of coping through observation, or she might be invited to try on the entire action sequence for herself, going from confined (standing with arms by sides and body tight), to an empowered stage of breaking free (moving arms and body), to sequencing energy through movement, rhythm, and sound (shaking arms, stomping feet, exhaling loudly, or vocalizing). In this way, Sarah has the opportunity to complete the necessary action sequence that was thwarted at the time of her early medical scans.

This is just one small example that highlights the ways in which a somatic therapist might use body psychotherapy principles in the playroom. Mirroring, movement, rhythm, breath, and vocalization interventions can be modified to be more or less directive, based on the therapist's orientation to play therapy. There is an almost limitless potential to the ways in which somatic interventions can be used in the playroom, the only guiding principle being that the therapist stays attuned and connected to their own body and affective experience, as well as those of the client. The attuned and regulated therapist can then model novel ways of dancing between states of dysregulation back to regulation, while staying connected to both self and other.

LIMITATION AND FUTURE STUDY

This theoretical model proposes that attunement, regulation, and interoceptive awareness are fundamental in the health and wellbeing of the child and offers a way to incorporate body psychotherapy techniques in the playroom. This exploration is precursory, and not an all-encompassing look into somatic play therapy techniques. Nor does the author contend that this model is a complete framework in and of itself for working with child clients. Rather, it is intended to set a foundation upon which therapists of differing play therapy modalities can build while incorporating their own orientations and unique lenses. Further, embodiment is a natural outcome of the securely attached child, but is a vast, and oftentimes hard-won, achievement for the traumatized individual. This can be especially true for children suffering from complex trauma, and thus an embodied approach to healing must be approached with care, titration, and consideration so as to not retraumatize the child client with intense somatosensory experiences.

The scope of this paper did not address other vitally important considerations for a somatic approach to play therapy, including but not limited to the therapeutic use of touch, transference and countertransference considerations, family system dynamics, power differentials between child and therapist, and important societal and cultural implications. These topics necessitate further consideration, research, and conversation as each show up in the playroom and impact the embodied and relational experience of both child and therapist alike. Despite somatic body psychotherapy seeming like a natural pairing to working with child clients, it is an as yet narrowly explored orientation in play therapy. More research and development should be conducted to adapt the work of prominent somatic therapists in the field, including the modalities of Aposhyan, Kurtz, Levine, and Ogden into working with child clients.

Conclusion

Play is a vital component of child development, and facilitates growth and healing across cognitive, emotional, and social domains. Play therapy is predicated on the belief that children will physically enact and express their inner thoughts and feelings through play and relationships. It is this healing relational dynamic that is of importance in the playroom as the therapist seeks to create an attuned and empathetic connection, helping the child regulate through emotional intensity and foster interoceptive awareness, thereby supporting the child to garner a newfound appreciation of their affective and somatosensory inner world. Somatic body psychotherapists work with, and through, the body using movement, breath, and rhythm to help clients access and integrate their physical and emotional experience. Within the framework of attachment-focused therapy and developmental neurobiology, body psychotherapy can provide a novel way of working with child clients, teaching children to regulate through emotional intensity, attune to both self and other, experience and name felt sensations, and ultimately find affective, somatic, and cognitive integration.

Appendix A

Signs of Hyperarousal/ Sympathetic Nervous System activation (Fight/Flight/High Freeze)	**Signs of Optimal Regulation/ The Social Engagement System**	**Signs of Hypoarousal/ Parasympathetic Nervous System Activation** (Collapse)
Fast speech	Congruent speech	Slow speech, no speech
Quick movements	Relaxed movement, ease in the body	Slow, heavy movements
Anger/Outbursts/Irritability	Connectedness to others, reciprocity	Tiredness
Difficulty concentrating	Aware of both self and other	Slow to engage
Short, quick breaths	Regulated breath	Slow breath, hard to see breath in body
Quick, rapid eye movements	Ability to make eye contact	Staring into space/dissociation
Anxiety	Regulation/Relaxed	Depression
Overly attuned to sensation and emotion	Ability to feel and name experience	Numbed from sensations and emotions
Exaggerated startle response	Feeling of safety in self and environment	Non-reactivity/lifelessness
Alert, tense, scanning for threat	Present, embodied	Disengaged, hanging head, slumped posture

Figure 1 ***Tracking the Nervous System****. Adapted from the work of Dion (2018), this graphic depicts signs of hyperarousal, regulation, and hypoarousal that offer important insights for the somatic body psychotherapist*

Appendix B

Part of the Brain Addressed	**Therapeutic Skill Used**	**Somatic Intervention**
Brainstem (The Body Brain)	Regulation- Co-regulation and Self-Regulation	■ Breath ■ Movement ■ Rhythm ■ Feel it to heal it
Limbic System (The Emotional Brain)	Attunement	■ Mirroring ■ Name it to tame it (Siegel & Bryson, 2016) ■ Feel it to heal it
Integration of the "3 Brains": Body Brain + Emotional Brain + Thinking Brain	Interoception	■ Body Map (Appendix 1) ■ Feel it to Heal It

Figure 2 ***A Somatic Approach to Working with Children: A Theoretical Model****. Adapted from the work of Perry (2006), this figure illustrates a somatic approach to play therapy with neurodevelopmental considerations*

Appendix C

Feel it to Heal It: Listening to My Body

Right now, I'm feeling: _____

Angry	Cheerful	Embarrassed	Loving	Sad
Alarmed	Compassionate	Happy	Nervous	Scared
Amazed	Confused	Lonely	Playful	Surprised

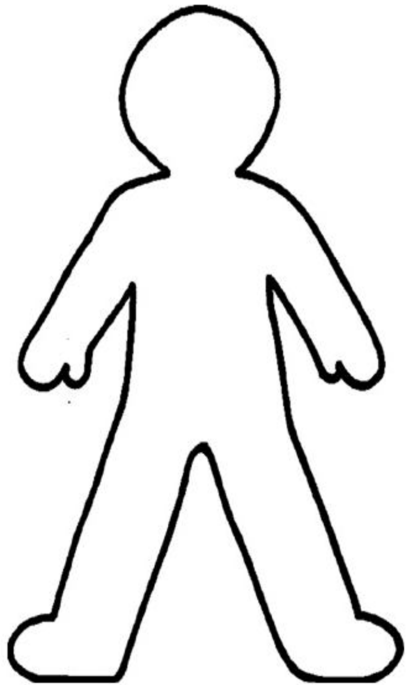
Some sensations I'm noticing are: _____

Achy	Buzzy	Dizzy	Heavy	Numb
Breathless	Clammy	Energized	Hot	Prickly
Bubbly	Constricted	Fluttery	Knotted	Sore

If this feeling + sensation could talk, it might say: _____

_____

This is where I feel it in my body:



This is what my body wants to do:
(Examples: Run, stomp, throw, curl up)

_____

_____

_____

_____

_____

_____

_____

_____

Feel it to Heal it Worksheet

Jennifer Taylor, MA, is a graduate of the Somatic Counseling program at Naropa University, where she earned her MA in Body Psychotherapy. She works as a somatic therapist, trauma therapist, and play therapist in Boulder, Colorado. She combines the wisdom of the body with the power of play to foster health and healing in clients of all ages.

Acknowledgment: This author would like to offer her profound gratitude to Polly Douglas, Andrew Rose, Mia Bertram, Mike Lythgoe, and Lisa Dion for their guidance, mentorship, supervision, and expertise in the fields of play therapy and body psychotherapy.

REFERENCES

Aposhyan, S. (2004). *Body-mind psychotherapy: Principles, techniques, and practical applications*. New York: W. W. Norton and Company.

Association for Play Therapy. (2014). *Why play therapy?* Retrieved from http://www.a4pt.org/?p.=WhyPlayTherapy

Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology*. New York: Norton, Inc.

Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice*, 36(4), 376-390. https://doi.org/10.1037/0735-7028.36.4.376

Caldwell, C., & Victoria, H. K. (2011). Breathwork in body psychotherapy: Towards a more unified theory and practice. *Body, Movement and Dance in Psychotherapy*, 6(2), 89-101. doi: 10.1080/17432979.2011.574505

Cozolino, L. J. (2010). *The neuroscience of psychotherapy: Healing the social brain* (2nd ed.). New York: W. W. Norton & Company.

Dion, L. (2018). *Aggression in play therapy: A neurobiological approach for integrating intensity*. New York: W. W. Norton & Company.

Dion, L., & Gray, K. (2014). Impact of therapist authentic expression on emotional tolerance in synergetic play therapy. *International Journal of Play Therapy*, 23(1), 55-67. https://doi.org/10.1037/a0035495

Gil, E. (1998). *Essentials of play therapy with abused children*. New York: Guilford Publications, Inc.

Kain, K. L., & Terrell, S. J. (2018). *Nurturing resilience: Helping clients move forward from developmental trauma – an integrative somatic approach*. Berkeley, CA: North Atlantic Books.

Kestly, T. A. (2014). *The interpersonal neurobiology of play: Brain-building interventions for emotional well-being*. New York: W. W. Norton & Company.

Kurtz, R. (2007). *Body-centered psychotherapy – the Hakomi method* (Revised ed.). Mendocino, CA: LifeRhythm.

Leggett, E. S., & Boswell, J. N. (2017). *Directive play therapy: theories and techniques*. New York: Springer Publishing Company.

Levine, P. A. (2010). *In an unspoken voice: how the body releases trauma and restores goodness*. Berkeley, CA: North Atlantic Books.

Lin, Y. W., & Bratton, S. C. (2015). A meta-analytic review of child-centered play therapy approaches. *Journal of Counseling & Development*, 93(1), 45-58. https://doi.org/10.1002/j.1556-6676.2015.00180.x, neurobiologyofplayPerry_Gaskill.pdf (n.d.).

Murphy, J., Brewer, R., Catmur, C., & Bird, G. (2017). Interoception and psychopathology: A developmental neuroscience perspective. *Developmental cognitive neuroscience*, 23, 45-56.

Ogden, P., & Fisher, J. (2015). *Sensorimotor psychotherapy: interventions for trauma and attachment*. New York: W. W. Norton.

Ogden, P., & Minton, K. (2000). Sensorimotor psychotherapy: One method for processing traumatic memory. *Traumatology*, 6(3), 149-173. doi: 10.1177/153476560000600302

Ogden, P., Minton, K., & Pain, C. (2006a). *Trauma and the body: a sensorimotor approach to psychotherapy*. New York: W. W. Norton.

Ogden, P., Pain, C., & Fisher, J. (2006b). A sensorimotor approach to the treatment of trauma and dissociation. *Psychiatric Clinics of North America*, 29(1), 263-279. doi: 10.1016/j.psc.2005.10.012

Perry, B. D. (2006). Applying the principles of neurodevelopment to clinical work with maltreated and traumatized children: The neurosequential model of therapeutics. In N. B. Webb (Ed.), *Working with traumatized youth in child welfare* (pp. 27-52). New York: Guilford Press.

Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation*. New York: W. W. Norton.

Schore, A. N. (2009). Relational trauma and the developing right brain. *Annals of the New York Academy of Sciences*, 1159(1), 189-203. doi: 10.1111/j.1749-6632.2009.04474.x

Schore, A. N. (2012). *The science of the art of psychotherapy*. New York: W. W. Norton.

Siegel, D. J., & Bryson, T. P. (2016). *The whole-brain child: 12 revolutionary strategies to nurture your child's developing mind*. Vancouver, B.C.: Langara College.

Van der Kolk, B. (2015). *The body keeps the score: brain, mind, and body in the healing of trauma*. New York: Penguin Books.

Wallin, D. J. (2007). *Attachment in Psychotherapy*. New York: Guilford Press.