Chapter 5

The Safe Space:
An Examination of the Neurobiological Benefits of Play Therapy with Traumatized Children

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ABSTRACT

This chapter illustrates the neurobiological effects of trauma on children, as well as the therapeutic benefits of play therapy as a stand-alone treatment for this population. The goal of this work includes providing a framework for the neurobiological effects of trauma on children, as well as the various advantages of play therapy as an effective intervention. Play, specifically, meets children where they are in their development, while also attending to the neurobiological effects that trauma can have on the brain. The primary neurobiological structures implicated and targeted by client-centered play-based interventions are discussed, as well as the impact play therapy has on neural integration, memory assimilation, and the limbic system. A clinical vignette from the principal author’s practice and experience working with traumatized children is included to elucidate the healing nature of play.

INTRODUCTION

Millions of children are exposed to stressful and traumatic events each year. Internationally, approximately 25% of youth are affected by sexual abuse, physical assault, or domestic violence, among other traumatic stressors (Cohen & Mannarino, 2008). According to the United States Department of Health and Human Services (2014), approximately 1,580 children died as a result of abuse and neglect in

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2014, and over 3 million suspected cases of child maltreatment were reported to authorities that same year. After a traumatic event children often develop clinically distressing or impairing symptoms that may manifest into various affective and anxiety-related disorders, such as post-traumatic stress disorder (PTSD). Furthermore, after the traumatic stressor has passed, the memory of the event, in conjunction with a sense of helplessness and lost autonomy, continues to cause extreme distress in the individual (Cohen & Mannarino, 2008; Cohen, Perel, Debellis, Friedman, & Putnam, 2002; van der Folk, 1994).

As the rate of traumatized children continues to rise, it is imperative to understand the neurobiological effects of trauma on survivors and to address these developmental realities and implications for children (Hong & Mason, 2016; Perry, 2009). Play therapy is a neurobiologically informed treatment in which emotionally disturbed children are encouraged to act out their fantasies and express their feelings through play with the guidance of a trained therapist (Schaefer & Drewes, 2014; Kestly, 2014; Gil, 2006; Wheeler & Taylor, 2016). Play, specifically, meets children where they are in their development, while also attending to the neurobiological effects that trauma can have on the brain. As a result, this chapter will broadly focus on the benefits of using play therapy with traumatized children. The conversation of trauma will focus on PTSD, as this disorder is becoming a common diagnosis for children and adolescents suffering from psychological and behavioral difficulties following a traumatic event (Ackerman, Newton, McPherson, Jones, & Dykman, 1998; Cohen & Scheeringa, 2009; Schwarz & Perry, 1994). This chapter will begin with a brief overview of PTSD, from a clinical perspective, and then will continue onto the neurobiological symptoms of the disorder. Subsequently, foundational components of play therapy will be detailed, followed by an explanation of how the play process addresses the neurobiological symptoms of children with a history of trauma. A clinical vignette will make up the final portion of the chapter to elucidate the healing properties and neurobiological benefits that occur in the therapeutic play therapy process.

**PTSD Basics**

Post-traumatic stress disorder is one of the most complex and pervasive mental health conditions affecting survivors of trauma (McDonald, Borntrager, & Rostad, 2014; van der Kolk, 2005; Ryan & Needham, 2001). One of the unique characteristics of PTSD, in terms of diagnosis, is that the presenting symptoms must be tied to a causal, traumatic event (Van Hooif, McFarlane, Baur, Abraham, & Barnes, 2009; Rothschild, 2003). Traumatic events are “psychologically overwhelming because they potentially threaten a [person’s] sense of safety and security and lead to subjective feelings of terror, fear, shame, anger, helplessness, and/or worthlessness” (Cohen, Mannarino, & Deblinger, 2012, p. 1). These experiences can be direct or vicarious in nature, but what truly defines them as traumatic and relevant for a PTSD diagnosis is the presence of “actual or threatened death, serious injury, or sexual violence” (APA, 2013, p. 271).

The severity of any one event will vary between children depending on several protective and risk factors, such as social support, preexisting coping strategies, the nature of the trauma and previous trauma exposures, and comorbid mental health conditions (Cohen & Mannarino, 2008; Caffo & Belaise, 2003; Pfefferbaum, 1997). However, several studies have shown that children having experienced trauma will invariably develop symptoms that may manifest into various affective, anxiety, or trauma-related disorders (Ackerman et al., 1998; Balaban, 2006; Grych, Jouriles, Swank, McDonald, & Norwood, 2000; McFarlane, Policansky, & Irwin, 1987). Some common symptoms of PTSD, which must persist for over one month to be clinically diagnosed, include: