

Play Therapy Treatment of Pediatric Medical Trauma: A Retrospective Case Study of a Preschool Child

Margaret G. Locatelli
Las Cruces, New Mexico

Play therapists have become sensitized to interpersonal trauma and its varied presentations and consequences. Children who experience frightening and painful medical procedures may become traumatized by these experiences. Personnel working in inpatient medical facilities are presumably familiar with emotional and behavioral presentations of pediatric medical trauma. However, underlying pediatric medical trauma may be overlooked in outpatient play therapy settings. This article describes the clinical case of a young child whose relatively severe emotional and behavioral problems masked medical trauma. Examples of thematic play sessions are presented to illustrate the child's underlying trauma and the process of play therapy that led to considerable improvement. The importance of the play therapy relationship is emphasized. Play therapists are encouraged to consider the presence of pediatric medical trauma when assessing young children with histories of medical intervention.

Keywords: pediatric medical trauma, play therapy, case study

In the past decade, knowledge about the long-term consequences of interpersonal trauma has grown in depth and breadth. As the complex connections between attachment patterns, neurodevelopment, traumatic experiences, and epigenetics have been elucidated (Hudspeth, 2017; Perry, 2001; Perry & Gaskill, 2014; Perry & Szalavitz, 2017; Siegel, 2017), play therapists have been better able to tailor treatments for their maltreated child clients.

Practitioners working in inpatient pediatric settings recognize that children in their care may be traumatized by invasive, painful, and/or frightening medical procedures. (Kazak et al., 2006) It is logical to expect that a subset of these children, those who exhibit emotional and behavioral symptoms, will be identified as medically traumatized. However, outside of an inpatient pediatric setting, it is presumably less likely that practitioners will recognize a child who presents with behavioral or mood-based

problems as suffering from medical trauma, even when that child has a history of traumatic medical procedures. Unless a referring professional or parent considers a child's history of difficult medical experiences pertinent to the child's presenting problems, his medical traumatization—which is potentially the foundation of the presenting symptoms—may be overlooked. Play therapists have generally become knowledgeable about, and sensitive to, issues of interpersonal trauma. It is crucial that medical trauma also be considered when assessing a child with a significant health or medical history.

The following case study describes play therapy in an outpatient office, with a preschool child suffering from unrecognized pediatric medical trauma stress. David's primary presenting problems were aggression toward others and himself, and intense mood changes. His behavior was at times totally dysregulated. While taking a health and medical history, the therapist learned that the child, David, had endured many painful, frightening, and invasive medical procedures beginning at 21 months of age.

David's parents gave permission for their son's history and therapy to be published. They have encountered many health and mental

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Correspondence concerning this article should be addressed to Margaret G. Locatelli, Independent Practice, 350 El Molino Boulevard, Las Cruces, NM 88005. E-mail: dmmaggielc@gmail.com

health providers who were unaware of, or minimized, the potentially traumatic repercussions of medical treatments on young children. They hope that David's experiences will alert play therapists working with young children in outpatient settings to consider the possibility of medical traumatization when the child's developmental and medical history reveals previous painful and/or repeated medical interventions.

This case study is also offered as a testament to the healing properties of play therapy. When a child and therapist form a relational bond, when the child experiences adequate structure and compassion that provide support and freedom, then the child will be able to do what she needs to in order to process previous traumas. It is under these circumstances that children can regain a sense of safety in the world, and their misinterpretations of threat can be overcome.

Literature

Diagnostic and Descriptive Considerations

For some time, medical personnel working with children hospitalized for life-threatening illness and injury have recognized pediatric medical traumatic stress (Kazak et al., 2006). The vast majority of research in this area has been focused on pediatric cancer patients and their families. A leader in this field is The Center for Pediatric Traumatic Stress, affiliated with The Children's Hospital of Philadelphia. One component of the Center is The National Child Trauma Stress Network (NCTSN), which is dedicated to disseminating information on all aspects of pediatric traumatic stress to providers and parents.

The Center defines pediatric medical trauma stress (PMTS) as "a set of psychological and physiological responses of children and their families have to pain, injury, serious illness, medical procedures and invasive or frightening treatment experiences" in medical settings (<https://www.nctsn.org/what-is-child-trauma/trauma-types/medical-trauma>). The majority of children and family members experience some transient trauma reactions to life-threatening illness, injury, or medical procedures. Between 15% and 25% of children "experience persistent traumatic stress reactions that impair daily functioning and affect treatment adherence and recovery" (NCTSN, 2014). In these cases, the

NCTSN recognizes that post traumatic stress disorder (PTSD) is usually the most fitting diagnosis. The concept of PTMS is not a medical disorder or diagnosis, but rather a "continuum of key symptoms . . . which may be present without meeting criteria for a full diagnosis of PTSD . . ." (Kazak et al., 2006, p. 344). PMTS and PTSD share criteria of hyperarousal, avoidance, and reexperiencing.

However, PMTS differs from PTSD in that it is specific to traumatic experiences related to medical pain, injury, and painful medical procedures. PTSD includes the criterion that a child has directly experienced or witnessed ". . . actual or threatened death, serious injury, or sexual violence . . ." (American Psychiatric Association, 2013).

Developmental and Attachment Considerations

The NCTSN emphasizes that it is the child or parent's subjective experience and interpretation of a medical event, rather than an external or objective evaluation of the degree of threat, that is highly correlated to the development of a traumatic stress reaction (NCTSN, 2014). In the case of children, developmental capacities and limitations are major inherent mediating factors in interpretation of a painful medical event: Because they are still developing cognitive skills, young children process information differently. For example, many preschool children associate pain with punishment and may believe they did something wrong when they are in pain, or that they somehow caused their illness or the injury. They can also get mad or frustrated with the medical provider administering a painful procedure. (NCTSN, 2014, p. 6)

Children who experience traumatic medical interventions may also suffer temporary disruptions in attachments to their primary caregivers as a component of their medical traumas. Possible relational disruptions, as the child's interpretation of experienced pain described above, is also significantly mediated by a child's age, and her understanding of her parents' role in medical procedures. A young child may feel betrayed by his parent(s) if, for whatever reasons, they have participated in activities that cause the child pain and/or fear, especially if these events occur repeatedly (Freyd, 2008). Simultaneously, the parent-child relationship

may also be affected by parental feelings of powerlessness, guilt, and/or inadequacy.

Case Study

Medical History

David's parents, both bright and responsible, were in their mid-20s when he was born. They were both pursuing graduate degrees. They had a second son when David was four years old. David's mother received prenatal care and had no problems during her pregnancy.

David was full term, and was a healthy baby and young toddler. He began walking at 8 months, preferred physical activity from an early age, and demonstrated a love of independent movement. His mother described David as well-coordinated.

When David was 21 months old, he experienced a febrile seizure, consequent to contracting a virus. He was seen at the local hospital and released the same day. Exactly one month later, at 22 months of age, David had another seizure, without any fever preceding it. The emergency room doctors had difficulty stopping his seizure activity. David's respiration was eventually depressed by the high dose of Ativan he was given in the emergency room to subdue his seizure activity. Consequently, he was intubated to receive oxygen, transported to a larger hospital by helicopter, and admitted to the ICU.

His mother recalled that while David withdrew from the Ativan, "For hours he screamed and cried while I held him. He was in an unconscious state but thrashing and scratching." David was given multiple IVs, which he fought to pull out. His mother described, ". . . we would have to hold him down while they fished for a new vein, and he never quit fighting." David and his parents stayed at the hospital for three days.

One day during the next month, when he was 23 months old, David became lethargic and nonresponsive. He was subsequently diagnosed with aplastic anemia, a condition caused by a viral infection in which bone marrow stops producing new red blood cells. David underwent an MRI, a spinal tap, and a CAT scan during his three-day stay in the hospital. Additionally, he was given two blood transfusions and, according to his mother, "countless IVs." David's parents were instructed to bring him every week for

a blood test and possible transfusion. David's mother recalls, "each time we would have to hold him down so the blood could be drawn. It would usually take several tries to get a vein."

Ultimately, a port-a-cath was surgically implanted in David's chest so that blood transfusions and blood draws would be somewhat easier. Even then, "each time we went it was chaotic. He would try and escape. He would have to be forced into a room and fight and try and run off repeatedly." David's port-a-cath was surgically removed early in 2013. He awoke from this procedure "terrified and fighting."

For about one year, David was seizure-free. However, in the summer of 2013, when he was approaching his third birthday, he began having seizures regularly. Despite the use of emergency suppositories and interventions at the ER, sometimes David's seizures would not stop. At times, his seizure activity lasted 40 min to an hour. In January 2014, David was diagnosed with medically resistant epilepsy.

David was seen at an out-of-state children's hospital when he was 3 years and 3 months old. He was there for eight days. David's brain activity was monitored constantly during that time by EEG equipment. In order to accomplish this extended EEG, hospital staff glued 20 sensors to David's head while his parents were out of the room. He was wrapped in a sheet with his arms pinned to his sides, and held down by a large male nurse in order to be immobilized.

David's father noted that this was a terrifying incident for David. The sensors had to be reattached repeatedly during the multiday EEG test. When the sensors were finally removed, acetone was used to remove the adhesive, which was very painful and left David with several raw and bloody places on his head. David has permanent scars on his forehead from this procedure.

During the week at this children's hospital, David also had an IV in for most of the time. His mother reported that by the time the week was up, most of the veins in David's arm had been "blown." He rebelled against many medical procedures vocally and physically. Despite his protests and aggression, his parents were solicited to restrain David multiple times.

Prior to his release from the hospital, David was diagnosed with idiopathic focal epilepsy, originating from his left occipital lobe, and status epilepticus. He had complex partial seizures

which frequently progressed to tonic clonic seizures.

One month after the family returned home from the hospital, David again began having seizures. He had at least one seizure each week for about four months. David was hospitalized locally during the first three seizures, and his emergency medication was subsequently changed so his parents could manage his seizures at home. David continued to need weekly blood draws, which were consistently traumatic for everyone—David, his parents, and the laboratory personnel. During these months, David's behavior was very erratic and aggressive.

During the two years David endured multiple seizures and many painful medical procedures, he was also on a variety of anticonvulsant and antianxiety medications. The side effects of these medications were often problematic, as they lowered David's threshold of frustration, increased his impulsivity, aggression, irritability, and sadness, and caused visual hallucinations. David's medication was changed fairly often as he remained medication-resistant. That is, each trial of anticonvulsant medication was only effective temporarily.

When David was enrolled in Head Start in the Fall of 2014, he had been seizure-free for about seven months. However, he was demonstrating severe behavioral and emotional problems. During his first day, his teacher reported that she observed David committing over a hundred aggressive acts toward children or their materials. David said of himself sometime soon after beginning Head Start, "I don't belong in school because I can't control my body."

When David entered therapy at 4 years and 7 months, his problematic behaviors included hitting and scratching himself and others, throwing prolonged temper tantrums, and bolting (usually running away from his parents or other authorities) into parking lots or into streets.

Meeting David

My introduction to David began in my "talking office," a rather spacious room furnished primarily for therapy with adolescents and adults. This is the room in which I meet parents and have family sessions. What I first noticed about David was his hair. It was unusually long for a four-and-a-half-year-old boy. Parted on the side, his hair covered one eye and half of his

face, creating a curtain he peered through. While I talked with his mother, David explored the room, handling the toys as well as some of the furnishings. His mother seemed nervous about what he might do and intermittently gently set a limit on his behavior, which David accepted and with which he complied.

After talking with his mother in my office, I invited David into the play room for an introduction to the space. I told him he could play with whatever he wanted to. I also assured him that I was not the kind of doctor who examined anyone's body. The only limit I set initially was that "No one gets hurt in the playroom." David was immediately drawn to the foam swords, and also quickly discovered the toy guns and retractable plastic knives.

In his initial play interactions with me, David used "monster" toys (action figures) to "tickle" me. Their friendly, playfulness quickly devolved and they became "scary," cutting off my hands and rendering me helpless. When I felt uncomfortable from the pressure David was using with the toys, I set a limit. I explained that in the playroom, he could express any feelings he had, but that no one was to be hurt. Accordingly, he became intentionally less aggressive, while he continued to use the figures to harass me. At the end of this brief play sequence, he used the figures to regenerate my hands.

David had introduced some of the major themes of the work ahead of us. The action figures had at first been playful, but then turned mean. I understood this to symbolize his experience of betrayal and his consequent fear of trusting "doctors." He also demonstrated his fear of being rendered helpless, certainly something he had experienced multiple times in the past during medical procedures. In relating to me in this brief introductory session, David had tested my boundaries in order to gauge his safety. Simultaneously, he had invited me to actively participate with him as a partner in play, thus communicating his willingness to work with me.

Impressions and Treatment Plan

After four play assessment sessions, I shared my impression with David's parents that the primary difficulty underlying his behavioral and emotional symptoms was unprocessed medical trauma. I diagnosed David with PTSD. He was

hyper-aroused and often combative in medical offices, labs, and other medical facilities. He was hyper-vigilant and aggressive in many unfamiliar situations in which he did not feel in control. He frequently demonstrated both fight and flight reactions in situations that exposed him to stimuli that were similar to aspects of medical facilities or situations he had experienced previously. His sense of self was distorted, and his trust in adults had been damaged. Additionally, David's attachment to his parents had been negatively affected. Amelioration of these problems was the initial goal of therapy.

His parents agreed for David to see me weekly for individual play therapy. They also agreed to meet with me periodically for parent guidance sessions. David's parents were relieved by my diagnostic impressions of their son, because his traumatic medical history had previously not been identified as the primary reason for his emotional and behavioral problems.

Processing Medical Trauma Through Play

Posttraumatic play. It is widely accepted that young children do not express trauma reactions as adults do. While adults may talk about their symptoms, young children are more apt to demonstrate the emotional and cognitive effects of trauma through play. The *DSM-5* includes specific criteria for the diagnosis of PTSD in cases of young children, age six and under (American Psychiatric Association, 2013). It notes that young children may use play reenactments to express posttraumatic feelings and experiences.

Eliana Gil describes the varied nature of post-traumatic play:

Children seem very intent in exercising fastidious movements and reiterating precise sequences over and over. They appear completely self-absorbed in the play—the typical interactive style of children's play is markedly absent. . . . Most children do not appear to consciously choose to play out their traumas; rather, it is as if the trauma material finds its way out of their unconscious into concrete form. . . . Others “act out” their traumatic experiences by engaging others in repetitive, reenactment behaviors, some of which possess literal elements of their traumas, particularly interpersonal ones. (Gil, 2013, p. 53)

David's play repertoire included many representations of his medical trauma. Some of these were explicit enactments of medical treatments. Other repetitive play sequences were not con-

crete replications of medical interventions, but rather metaphoric representations of his traumatic experience and consequent feelings of pain and powerlessness.

One play theme which David introduced early in his treatment and repeated several times is illustrative of nonmedical posttraumatic play. In this play, David populated the sand tray with several toy animals. He used different animals in each session, but usually included several wild predators, such as alligator, lions, tigers, and snakes. One by one, the toy animals “bit” David's fingers, causing painful and “bloody” injuries. After every biting occurrence, David directed me to put the offending animal on “time out” for its bad behavior. I admonished each animal for hurting David, and then placed it, as directed, under the sand tray. A few times, David “cried” silently, with open mouth, a stricken facial expression, and wrenching movements. This play sequence, dream-like in quality, became very predictable, and, other than directing me to reprimand the animals, David did not interact with me during this play.

I introduced the doctor kit during one of the sequences when toy animals repeatedly bit David. Such an intrusion into a child's play has to be done deftly and with care, as it derails the child's own process. However, if a therapist chooses the right time, and intervenes in a way that actually facilitates the child's play process, adding to or changing the story line slightly can be beneficial (Gil, 2010; Irwin & Curry, 1993). When I decided to use the doctor kit, the intrusion was based on my observation and feeling that David was stuck in this rendition of his posttraumatic play. I put a bandage from the kit on his fingers, hoping to demonstrate my intention to decrease his (emotional) pain. I also hoped that introducing the doctor kit to the play might open the door for more direct medically oriented posttraumatic play. David was apparently open to the addition of the kit, as he stated that his fingers “felt better” after I bandaged them.

Abreactive play. Abreaction is understood to be a psychological process by which someone who has previously been rendered passive, usually in the context of interpersonal aggression, symbolically turns their powerlessness into action (Oremland, 1993). It is considered to be one means of psychologically working through and resolving certain aspects of trauma

(Oremland, 1993). Abreaction was evident in much of David's play. He often adopted an active, sometimes symbolically aggressive role in play, in contrast to his previously experienced forced passivity during medical procedures.

A version of nonmedical posttraumatic play that included abreactive elements occurred when David played out the role of an aggressor with me. In these sequences, David directed me to remain passive as he repeatedly "cut" me using foam swords, retractable knives, and a plastic dagger. At times he directed me to cry or express fear, which he ignored. This play, and others like it, clearly communicated the confusion, anger, and betrayal David most likely felt when his protests (tantrums) about painful procedures were, from his vantage point, ignored by both his parents and medical personnel. This play allowed David to turn his experiences of enduring fear and pain into action—as he symbolically caused me pain.

After I introduced the doctor kit, David frequently initiated posttraumatic dramatic play sequences that seemed to be transparent representations of his traumatic medical experiences. These sequences were primarily abreactive in that David took an active role as someone both inflicting pain and treating it. In doing so, he represented both aspects of treatment he had received from medical personnel and his parents. During multiple medical procedures, adults had caused him pain. Adults, sometimes the same ones, had also comforted him. In portraying both the harmer and the healer, David proceeded to do some of the key work of his therapy.

During repeated sessions, David "cut" me multiple times, usually using foam swords or plastic daggers. Subsequently, "Dr. David" ministered to my multiple wounds. This play differed slightly from week to week. One week, following his examination of my pretend injuries, Dr. David pronounced "you are sick!" and performed multiple "blood draws" on me, after which he applied bandages. The next week, after repeating the sequence of injuring and doctoring me, he again drew blood but then explained that this procedure was necessary in order to help me. Then, as before, Dr. David put multiple bandages on me and asked me to not take them off.

During another session, David directed me to "cry" when he furiously and repeatedly took my blood. This time, he laughed sadistically as I continued to express pain. This was the single time Dr. David appeared as a maniacal frightening physician. Typically, Dr. David, unlike his role as the aggressive "cutter," was matter-of-fact, logical, and gentle. In this interaction, David clearly was symbolically identifying himself with medical personnel who he had felt were lacking empathy while he was suffering. Crenshaw (2016) clearly defines this defense of "identifying with the aggressor":

Children who have either witnessed or been subject to violence invariably feel powerless, terrified, and voiceless. In fantasy play they can assume the role of the powerful one, the victimizer instead of the victimized, which is understandably gratifying for the child. (p. 219)

These varied abreactive play sequences that David produced had an intensity that revealed their salience as a pathway for his expressing, integrating, and working through feelings associated with being rendered helpless during medical procedures.

Mastering Self-Regulation

Some of David's other play symbolized his struggle to regulate his behavior. The theme of this abreactive play centered on his experience that he was not consciously able to control his body. In one of these play sequences, introduced early in treatment, David adorned himself with a brightly colored bead necklace. He proclaimed that the necklace turned him into "a monster." In this transformed state, he was "scary and mean." As soon as he removed the necklace, he reverted to being self-identified "nice David." He repeated this transformational sequence multiple times in each of several sessions. When he dramatized becoming monstrous, David frequently lay on the floor and flailed about, moving his head, arms, and legs spasmodically, while he produced guttural noises. This play was so idiosyncratic, I wondered if it could be a representation of David's semiconscious memories of his seizure experience.

Although repetitive, this play was dynamic and meaningful. The content of the sequence gradually changed over months. Then it changed in a significant way when David explained that the necklace no longer had evil

power, and he could wear it without becoming a monster.

The following week, David revised his narrative slightly, and explained that the necklace that had previously automatically turned him into a monster was now in his control. He could determine how he would behave when he wore the necklace. Two weeks later, David re-explained, and demonstrated, by putting on the necklace and remaining himself. He had become stronger than the necklace's power. This shift in the play represented a monumental change in David's experience of himself. He felt in control of his actions, and therefore had taken a huge step in healing the traumatic aspect of passivity and helplessness. This change was echoed in David's behavior outside therapy, which had improved considerably. It was clear that David had completed, through play, that piece of work.

Family Themes

I understood some of David's play to reflect his view of the familial trauma associated with his medical treatments. David introduced this play five months after his therapy started. It was striking that this play was very different from the posttraumatic play sequences described above. David did not invite me into this play. He narrated the story line while I observed.

While playing in the sand tray, David singled out a young dinosaur who had lost his family, all eaten by a dragon. After a harrowing search all by himself, the little dinosaur found his empty house (the doll house, across the room from the sand tray). Resigned to his solitude, he went about his day—watched TV, used the bathroom, and went to sleep. After he woke up in the morning, the young dinosaur was very happy when his family magically appeared outside the house, and he was reunited with them.

David elaborated this story in the following two sessions, always including themes of separation and reunification. In these sessions, the young Dinosaur and his family members are all depicted as passive victims to dangerous circumstances. The safety of family connection is destroyed by external threats, and no one is able to do anything about it.

In a later session, David altered the story. After surprising the young dinosaur when they reappeared, the family together fought off the

dragon and vanquished him. The next week, David shifted the narrative yet again. Each member of the dinosaur family was killed by a different dragon. Then the dragons felt sad, remorseful about killing the dinosaurs. They breathed fire (the element they used to destroy) and brought the dinosaurs back to life. The dragons then joined the dinosaur family in one happy group. David asked me to take "photos" of each family member and then all of them together, commemorating the unification of dragons and dinosaurs. David was delighted by the conclusion of this play. I understood David's narrative of the dinosaur family fighting off the dragons to symbolize his sense that his parents were united in trying to protect him from anything that would threaten his well-being, even when, at times, they were overwhelmed themselves.

Relational Themes

Much has been written and discussed about the powerful and healing nature of the play relationship (e.g., Axline, 1969; Gil, 2002, 2010, 2013; Guerney, 1993; Moustakas, 1970). It is a unique and marvelous process, woven from a myriad of interactions between therapist and child, that encompasses both the growing connection between two real persons as well as all the elements of symbolic roles directed by the child. Louise Guerney (1993) a relationship-oriented play therapist, has stated,

It is not just fun together that makes for the strong adult-child bond, but it is the sharing of the child's inner self with the adult in a play context. In fantasy play, the child can do what and be what he wants without ridicule or interference. . . . The person who shares in those explorations with the child takes on a very special meaning in the child's life. Play allows that to happen as it could not in other therapeutic modalities. (p. 272)

In addition to being a unique interpersonal connection between one child and one therapist, the play therapy relationship is, hopefully, also a template for the child's new expectations of, and interactions with, helping adults. Children who come to therapy having suffered some form of interpersonal trauma have experienced violations of their physical and emotional integrity. Oftentimes, the physical violations they have endured have been painful, and committed by a previously trusted adult(s). The structure of the play therapy relationship replicates the

structure of these relationships in certain respects. Therapists typically meet with young clients privately and suggest, either implicitly or explicitly, to them that they are a special sort of friend or doctor, someone concerned about the child's welfare. Therapists convey their expectation for the child's cooperation. Each or all of these elements may be reminiscent to the child of aspects of a previously traumatizing relationship. In these ways, it may be distressing to the child, and simultaneously present opportunities for reparative experiences.

Quite early in therapy, David brought in photos of himself with his family to show me. Later, when he started kindergarten, David brought me a crown he had colored the first day and gave it to me. By these and other offers of sharing himself, I understood David to be letting me into his world. About three months after his therapy started, he pronounced his growing affection for me. As we entered the playroom for his 11th session, David said in a matter-of-fact way, "I love you." Such an affectionate statement is not uncommon for young children to make as they feel more trust in a therapist. I heard this acknowledgment from David as just that—letting me know he was beginning to trust me, and had hope I could help him feel better. Of course, this declaration of positive feeling also stirred up some conflicts for David. He told me in another session soon afterward that he loved his Mom—and only his Mom.

Some of the play sequences described above include relational elements, but certain play interactions specifically reflected David's emotional experience of our working relationship. In this vein, certain behavioral indications of cooperation and mutuality are noteworthy. In an early session, for example, David spontaneously allowed me to "win" in a marble game for which he had made up fluid and perplexing rules, and which I had lost multiple times. In another session, David gave me a toy shield as we were fighting with foam swords, offering me equal protection in our playful "battle."

Our relationship was occasionally the salient content of a fantasy play narrative. In the beginning of the fourth month of this treatment, David ended the session with a new piece of dramatic play, in which we pretended to be "camping." David turned the overhead light out, and used a large flashlight to represent a campfire. We lay down, each covered by our own

blanket. David was obviously a little nervous in the darkened room. He stressed the importance of the campfire, which would keep us warm and illuminate the dark through the night. We woke up in the morning—probably a minute later. I experienced this brief piece of play as poignantly expressive of David's hope for our working relationship—"Can we figure out what we need to, even if it's scary? Will you stay with me to figure it out?" This brief scenario was repeated during the following two sessions.

Termination

My work with David was interrupted due to a health crisis. I fell in May of 2016 and sustained a traumatic brain injury. During my weeks out of work, I received a brief phone video message from David, through his mother, telling me he hoped my head was better, and that he would "never, ever, never forget" me.

As I recovered and returned gradually to my schedule of meeting with therapy clients, it became clear to me that I would need to terminate with David due to my ongoing symptoms.

David had made considerable progress, and I did not think it wise for him to be out of therapy for a prolonged period. I contacted David's parents and let them know I thought it best for me to refer David to a colleague.

I met with David and his parents to explain the situation to him and say "good-bye." During that session, I presented David with a few toys symbolic of our work together and the changes he had made. I referred David to another therapist and let his parents know I would remain available to them for consultation until they were working with someone else.

David's parents contacted me several months later. The referral I had made to another play therapist had not worked out, and they had been on the waiting list at a community mental health clinic. David was working with an occupational therapist through the schools, and was enjoying the activities and the relationship with her. I believed occupational therapy was probably very helpful, not only for David's fine motor coordination, which was the identified reason for the therapy, but also for facilitating improved sensory integration, self-regulation, and confidence. He was doing well in school, mak-

ing friends, and was more developmentally “on track” in multiple domains.

I agreed to provide regular consultation to David’s parents. They, too, had been traumatized by David’s medical experiences, and had struggled with his very challenging post-traumatic emotions and behaviors. My work with them addressed their PTSD, parenting skills, and interpersonal communication.

Postscript

David’s parents brought him in to say hello almost two years after I terminated therapy with him. He was seven years old and about to end first grade (he repeated kindergarten). He had recently joined a basketball team. His parents told me he was doing very well with the team, although it had been a little confusing for David to be told he should be “more aggressive” on the court.

David recently traveled out of town for his annual check-up with a pediatric neurologist. He had to have an extensive EEG, lasting many hours, both awake and asleep. David had no difficulties with the process, although it was very demanding. When he left the facility, he was a little teary, and was able to say to his parents “I’m very tired and I don’t want to talk.” He fell asleep on the drive home.

Mother’s Retrospectives

I specifically remember feeling helpless before taking David to play therapy. He would get very angry and lose control. When he lost control he would hit, bite, and scratch. If you were drinking a glass of water and set it down, he would knock the cup over. It was like he was constantly fighting himself and everyone around him. . . . In the beginning I was terrified to take David to therapy. I was scared that he was going to hurt the therapist or just have a meltdown and run off. I sat anxiously in the waiting room wondering if he had done something that was going to lead us in another direction. I remember thinking he was going to do something that would mean the end of therapy. However, we kept coming and while I imagined that the sessions were difficult, he was able to stay in the room. That alone was an accomplishment at the start, because I didn’t know how he was going to be kept from leaving the room. . . . The results were not immediate, but it did not take long to see a change, and the changes that occurred over time were astounding.

Father’s Retrospectives

During his time in play therapy David’s mood and behavior changed dramatically. I noticed his mood

swings lessened and his sweet side came out more. He wouldn’t let us get too close to him and hug or cuddle him before starting play therapy. After he was in for a few months he started to get more affectionate. We also noticed that he became easier to communicate with. After speaking with you about how to interact with him, we were better able to communicate with him. We were able to talk about how he was feeling and rationalize some of his experiences. As we continued over the years his violent outburst slowed and eventually disappeared. He went from expressing himself mostly physically, to readily cuddling and talking about how he was feeling.

Conclusion

David’s ability to use the process of play so robustly was perhaps primarily due to his age, and stage of development while he was in treatment. He started play therapy sessions at four-and-a-half years old and I terminated with him two months before his sixth birthday. He was able to engage in fantasy play with no self-consciousness or hesitation. He was one of those children who seem to naturally understand the importance of the work of play therapy. However, the intensity of his play clearly reflected his need to process his previous traumas. While David was engaged in this work and after his therapy ended, his parents’ worked tirelessly to understand and respond to David’s needs, seeing beyond his aggressive behavior and breath-stopping “flight” reactions.

Medical trauma is garnering more attention, but the focus still often remains on children who are seen in pediatric settings. Play therapists who work with young children outside medical settings need to become attuned to the possibility of medical trauma, even if this is not identified as a presenting issue. A child’s experiences of painful or frightening medical procedures may be revealed when the therapist completes a sensitive assessment, including a thorough developmental and medical history. Therapists also need to educate the child’s parents and teachers about the connections between medical trauma and behavioral and emotional difficulties. The younger the child, the more unlikely it is that she will be able to clarify the conscious connection between her previous frightening or painful medical treatments and her states of hyperarousal, her fight/flight reactivity, and her dysregulated behavior and moods.

For a child struggling with medical trauma, play therapy can provide optimal opportunities for her to express her residual fears, hurt, and rage associated with this form of interpersonal trauma. Ideally, she will be able to use the play, within a strong therapeutic alliance, to explore and begin to heal many of the residual wounds buried after her medical traumas. As she matures, a child may need to revisit some of this history. If he does not recall early medical trauma, it may be useful, depending on multiple factors, for him to be told why he gets so nervous before a doctor or dentist appointment, or why he does not want to see his friend who is in the hospital. Having conscious, factual knowledge of his own life history may enhance his self-awareness even as an adolescent or adult.

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