**Somatic Experiencing®, A Body Oriented Approach to Healing Infant and Childhood Trauma**

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*Consciousness has no more influence on our actions than a steam whistle has on the locomotion of a train...*

Thomas Huxley

Roger Sperry[[1]](#footnote-1) (1952), made the distinct point that *the fundamental basis of perception derives from motoric potentiality.* It is through engaged movement that each infant generates a pre-verbal sense of “body-self” - a sense of bounded self with agency and power.

In experiments prompted by the 'Sperry Principle', Held and Hein (1963) asked their subjects to wear special prism goggles that made everything appear to be upside down. After some time (usually a week or two) the brain adapted such that the environment appeared to be normal (right side up) again. This occurred however, *only* if the subjects were free to move about actively, touching and manipulating their environments. The subjects who were not allowed to move around and explore did not experience visual normalization. Similarly, infants or children who engage in successful motoric actions are able to “renegotiate” experiences of terror, helplessness, and inescapability (Levine, 2010, Payne, Levine and Crane, 2015).

The basis of an 'unconscious' readiness to act was demonstrated in a later landmark series of well replicated experiments conducted by Benjamin Libet[[2]](#footnote-2) (1985, 1992, Libet et al 1996*.*) In a deceptively “simple” experiment, Libet instructed his experimental subjects to move a finger “at will.” However, based upon brain wave measurements he recorded electrical activity (in the pre-motor region) a full thirty seconds before they were aware of deciding to move it. This research clearly demonstrated that motor action itself, and the sense of agency that comes along with it, depends on neurological events that “we” (as in our conscious selves) do not control and that happen significantly *before* our conscious decision to act ( i.e. before the awareness of our impulse to protect, defend, pursue, etc.).

The primacy of movement is essential in working with early and pre-verbal trauma. Motor patterns that have been thwarted, overwhelmed or incomplete will color the entire perceptual field of the child and later the adult (Levine 2010, 2015). Hence transmuting these thwarted motor actions can greatly alter the children’s pre-reflective sense of self.

The essence of our core, pre-conscious “body-self” is explored from an analytic and psychodynamic perspective by Krueger (1989). Krueger exemplifies an emerging view in developmental theory: that the core (pre-conscious) 'body-self' comprises an aggregate experience encompassing a wide range of (embodied) sensory, kinaesthetic and proprioceptive input. Craig (2002, 2009, 2001) has shown how critical body sensations (interoception) are central to core regulation and as such, to our sense of wellbeing.

Let us see how these principles can be put into action in the “renegotiation” of a traumatic experience, from helplessness and overwhelm, to empowerment and agency. This physically sensed transformation is illustrated in the case of Jon, a fourteen month old, who suffered severe birth trauma and an abrupt separation from his mother along with invasive medical procedures. For Jon, this led to a subsequent failure to mold and attach to his mother. The second example is of Sammy, a two and a half year old toddler, who had a terrifying emergency room visit after a bloody fall.

**Baby Jon:**

**A mother and child reunion**

Jon is a bright and energetic toddler, yet at the same time painfully shy and reserved. He had been referred to me by a colleague because Jon had struggled through a very difficult birth and was presently contending with the sequelae to that ordeal. At fourteen months old, Jon was now being evaluated for yet another invasive procedure. This time, to investigate a condition of intermittent gastric reflux. His mother, Erika, was dutifully following through with the pediatrician’s recommendations and had scheduled an endoscopy for two weeks from the day of our first session. While she appreciated the pediatrician’s thoroughness, Erika was hoping that there might be another solution; one that was not invasive and potentially traumatizing.

Jon had been in a breach position leading up to labor, with the umbilical cord wrapped three times around his neck while his head was caught high up in the apex of the uterus. Each push he directed with his tiny feet and legs drove his head into a tighter wedge, while further constricting the cinch around his throat. This was a “no exit” ordeal evoking a primal strangulation terror, something that is difficult for most adults to comprehend (Martinez-Conde and Macknik, 2013). The doctors noted Jon’s serious distress; his heart rate had dropped precipitously, indicating a potentially life-threatening situation and an emergency Cesarean-section was performed. In addition to the C-section, a forceful suctioning was required to dislodge Jon’s head from the uterine apex. He was then whisked away from his mother. Jon's arrival into this world was accompanied by multiple clinicians poking and prodding him, plying their trade with the necessary needle sticks, IV insertions, aggressive examinations, and rushed interventions.

I saw Jon sat astride his mother’s hip as I opened the door and interrupted her second knock. She looked somewhat abashed as the follow-through on her rapping propelled her across the threshold and into my office. Regaining her composure and adjusting her son’s position, she introduced Jon and herself. I countered by introducing myself to each of them as Peter and inviting them inside. As they moved through the entryway, I noticed a slight awkwardness in the shared balance of mother and son. I could have dismissed this as a general unease with a new environment, an unfamiliar stranger, and an unknown form of therapy. However, it seemed to be more fundamental than that; there was a basic discordance in their dyadic rhythm.

It is often assumed that when there is a disconnection between baby and mother, there has been a failure on the part of the caregiver to provide the “good enough” environment required for bonding. This is not always true, and was clearly not the case with Erika. She earnestly and lovingly provided comfort, support, and attention. It was, rather, the traumatic birth that caused a jolt, splitting them apart at birth. The subsequent “shock wave” disturbed their mutual capacity to participate in each other’s most intimate moments, to fully bond and attach.

Following his gaze, I could see that Jon was intrigued with the colorful array of toys, musical instruments, dolls, and sculptures that were crowded onto the shelves above my table. I picked out a turquoise Hopi gourd rattle and began slowly shaking its seeds. Using the rhythm to engage baby and mom, I made eye contact with Jon and called out his name. “Hi, Jon,” I intoned in rhythm with the rattle as I gently leaned forward towards him and his mom.

Jon tentatively reached out for the rattle, and I slowly extended my arm to offer the handle to him. He quickly pulled back in response to my overture, but then tentatively reached for the rattle again, this time with an open palm. On contact, Jon pushed the rattle away and turned toward his mother with a faint whimper of distress.

Erika responded by securing her hold on her son and rotating away from our interaction with a quick spin. He was distracted, looked away, and became quiet. Keeping a comfortable distance, I began speaking empathetically to Jon about his difficult birth, talking *as if* he could understand my words. While it is, of course, unlikely that Jon would understand the precise meaning of my words, I believe that communicating as if he would conveyed more than the words themselves; that it was a reflection of his distress and a recognition that I “got him”. My prosody and tonal modulations seemed to give him some comfort and reassurance, conveying the feeling tone that I was an ally and somehow understood his plight.

Recovering his calm, Jon reached out again with curiosity and then pointed toward the table. “Apple, apple,” he said, extending his left arm toward a plate holding three pomegranates. I lifted the plate and offered them to him. He reached for the pomegranates, touched one, and then pushed it away. This time his push was more assertive. “You’re into pushing, aren’t you?” I asked, again communicating not only with words but with rhythm and tone. “I sure can understand how you might want to push, after all those strange people were poking and hurting you.” Wanting to reinforce his pushing impulse and his power, I offered my finger to him; he reached out to push it away. “Yeah, that’s great,” I responded, conveying my feelings of encouragement, warmth, and support. “You sure want to get that away from you, don’t you?” Jon let go another whimper, as if he agreed.

Erika sat down on the couch and began removing Jon’s shoes. He seemed fearful and turned away from the two of us as we talked about his gastric reflux and its possible penetration into his lungs. When Erika mentioned that the pediatric surgeon was proposing an endoscopy, Jon seemed to show a flash of distress: His face scrunched downward in a frown of worry and anxiety as he called out, “Mama.” Jon seemed to have recognized the meaning of our words (or was perhaps picking up on his mother’s unease), and in a millisecond, his mid-back stiffened and he turned toward his mother. I quietly asked his permission and then gently placed my hand on his mid-back, resting my palm over his stiffened and contracted muscles while extending my fingers upward between his shoulder blades. Jon whimpered again and then turned to look directly at me. Given that he maintained our eye contact, I assessed that it was safe to proceed with the physical touch. Jon continued to connect with me visually as his mother recounted the history of his symptoms, treatment, and medical assessment.

Then suddenly, Jon pushed mightily against his mother’s thighs with his feet and legs, propelling him upward toward her left shoulder. This movement gave me a quick snapshot of his previously, incomplete propulsive birth movements. These were the instinctual movements (the procedural memories[[3]](#footnote-3)) that had driven him into the apex of her uterus and strangled his throat with the cord — exacerbating his distress while further activating his drive to push, creating in turn, even more distress. As if following a dramatic, choreographed script, Jon pushed hard against his mother’s legs twice more, propelling him again up to her shoulders.

This completion of his birth push - without the previously associated strangulation, intense cranial pressure, and “futility” brought on by his head wedging into the uterine apex was an important sequence of movements for Jon to experience. It allowed him a successful “renegotiation” of his birth process in the here and now. His procedural memories had begun to shift from maladaptive and traumatic, to ones that were empowering and successful. Maintaining a low to moderate level of activation in this renegotiation was essential. I quietly removed my hand from his back and allowed him to settle.

His mother responded to his thrusts by standing him up in her lap. While I maintained a soft presence with an attentive, engaged gaze, Jon looked directly at me with a fierce intensity that seemed to express his furious determination. His spine elongated and he seemed both more erect and more alert.[[4]](#footnote-4) I again reached for Jon’s mid-back and spoke soothingly: “I wish we had more time to play, but since they are planning this procedure in a few weeks, I want to see if we can do something to help you.” Jon stiffened again and strongly pushed my hand away with his. He grimaced and flashed me a look of snarling anger while simultaneously retracting his hand and priming for another major defensive push away.

Leaning slightly toward Jon, I offered him some resistance by bringing my thumb into the center of his small palm. By matching his force and allowing him to push me away with his strength, I observed that, as his arm extended, he was able to harness the full-throttle power of his mid-back and then follow through with a robust thrust. We maintained eye contact and I responded to his expression of concerted aggression by opening my eyes wider in surprise, encouragement, excitement, and invitation. Jon continued to hold my gaze, as he pushed my hand away with significant determination his response transformed into one of seeming celebration. I reflected back to him his great triumph over an unwelcome intruder, an intruder who characterized his earliest experience of a threatening and hostile world.

Jon pulled his hand back and let go with a small whimper. But still he maintained eye contact, giving me an indication that he wanted to go on. Jon’s cry strengthened into deep sobs as he gave one more strong push to my thumb. He howled with apparent anguish, confusion, and rage. Slowly his cry deepened, becoming more spontaneous after I placed my hand again on his back. This invited the sound to come through his diaphragm in deep sobs. As he pushed my hand away once more, I spoke to him about all those people touching and poking him and how much he must have wanted to push them away too.

Jon broke away from our eye contact for the first time in this series of pushes and turned toward his mom. She reciprocated by gently connecting with his need for ventral support. With that brief interlude of respite, Jon turned back to re-initiate our eye contact even as his cry deepened. I responded to his cry with a supportive, “Yeah… yeah,” matching his anguish with a soothing, rhythmic prosody. Jon took a deep and spontaneous breath for the first time. He turned his chest fully toward his mom while looking over his shoulder to once again return my eye contact.

Jon continued to cry, but remained relatively relaxed. We paused for a moment, since I could see that Erika was consumed by many thoughts and feelings of her own. She took a deep breath and then looked down in amazement at her son. “He never cries,” she said. “Or rather, he cries with a little whimper, but never fully like this!” I reassured her that it seemed to be a cry of deep, emotional release. Erika paused and then added, “I mean, I can’t remember the last time I actually saw tears running down his face.” A grateful astonishment seemed to light up her face, while opening an energetic connection to her son.

When offered the opportunity, Jon reached out from his nested position and assertively pushed my finger out of the vicinity of his territory. I reinforced to Erika how profoundly disturbing it must have been for him to have strangers probing him with all those tubes and needles, how very small and helpless he must have felt. Erika repositioned herself as he burrowed deeper into her lap and chest.

Jon nestled into his mother’s lap with a new molding impulse, hitherto unseen by her. Molding is the close physical nestling of the infant’s body into the shoulder, chest, and face of the mother. When reciprocated it is a basic component of bonding—the intimate dance that lets the infant know that he is safe, loved, and protected. I believe that it also replicates the close, contained, physical positioning of the fetus in the womb and conveys similar primal physical sensations of security and goodness.

“I’m not sure what to do with this,” Erika commented, pointing with her chin to his nuzzling and snuggling shape. We paused together for a moment to appreciate this delicate contact between the two of them. “Whoa!” she said, breaking the silence. “He is really hot.” I commented that heat was part of an autonomic discharge that accompanied his crying and emotional release.

Jon settled down as Erika rocked him gently, maintaining full, yielding, chest-to-chest contact. He took in an easy, full inhalation and released it with a deep, spontaneous exhale that sounded both ecstatic and profoundly stress relieving. Indeed, Erika also let down her guard as well, shedding her doubt and beginning to trust that this new connection was “for real.” She looked down at her son as he continued to mold deeply into her chest and shoulder. She bent forward to meet his molding with her head and face. The two could be said to be “renegotiating their bonding.” Erika continued to gently rock her son while maintaining their connection. He continued to regulate himself with a gentle trembling and then took several deep, spontaneous breaths with full and audible exhalations. Erika quietly released her head backward and momentarily closed her eyes in an ecstasy of contact and connection.

After a few minutes, Jon peered out from his burrow and made eye contact with me. I recognized that he had had enough for one day, so I began to wind down the session. Erika acknowledged the closing, but needed to again share her own process of astonishment and hope. With a perplexed and startled expression, she noted, “I’ve just never seen him be this still.” Then she asked Jon, “Are you asleep?” And then on her next breath, “so sweet, oh so sweet,” she intoned as if getting to know her baby for the first time.

 Before the end of the session, Jon and I played Peekaboo with a warm and playful engagement for a few moments; however, at no time did he leave the cradle of his mother’s lap. She nuzzled his head and mused: “This really seems different. Usually he gives a quick hug and then is off on his way.” Almost as if smelling her newborn and drawing him in to her chest, she too let out an audible exhale and broke into a broad smile. “This is so very strange,” she murmured quietly. “He is affectionate, but never still … he never stays with me … he’s always off to something new.” As they continued to snuggle, they smiled in tandem. Their absolute delight was visible and palpable. Her baby had come home and they celebrated, together, that reunion.

At our next session, one week later, Erika had a number of anecdotes she wanted to share. Her upbeat excitement and Jon’s comfortable curiosity were contagious. They sat down together on the couch, Jon resting his head against his mother’s chest. I leaned forward in my chair, eager to hear her report. She began by recounting an episode that had occurred the night after our first session. “He woke up in the middle of the night and called out, ‘Mama,’” she reported, adding that she went to pick him up as usual. Jon sat quietly on her lap and pulled his head down deeper into her chest. “When I picked him up, he was doing this,” she added, pointing with her chin to his comfortable snuggling. I watched with an appreciative smile. “Looks to me like he’s making up for lost time,” I suggested.

Erika resumed her story: “Well … and then he said, ‘Apple, apple.’ I thought he wanted something to eat, but normally this would include him wiggling out of my arms and running to the kitchen. So I realized he must have been talking about the ‘apples,’ the pomegranates, on your table.” She explained that after their last session with me, later in the week, they had an appointment with the pediatrician which had upset Jon. While they drove home in the car he kept calling out to Erika from his car seat, “Pita, pita, apple, pita.” “Again I thought he was hungry,” Erika continued, “and responded by asking him if he wanted pizza. ‘No,’ [he answered]. ‘pita, pita, apple!’ I realized he was talking about you, trying to say ‘Peter.’ Pretty amazing, isn’t it, how much he recognized and wanted to talk about the change he felt?” she queried, looking up at me for validation.[[5]](#footnote-5)

I smiled with shared enjoyment and appreciation, and then asked about his energy. Erika replied, he has been so much more talkative, much more interactive. He wants to show us lots of things and then wants our feedback. He seems much more engaged and interested in having us play with him.” She bent down and kissed his head as he curled up in her lap. “But really, this is the biggest change,” she said. “I can’t tell you — for him to sit and just be cuddled, it’s a complete change, completely different. It’s not him … or ... it’s … it’s the new him.” “Or maybe it’s the new us,” I responded. Erika tipped her head shyly and spoke, ever so softly. “It’s wonderful for me.”

Jon and I played for much of the rest of this session. I recognized that much of the birth trauma and interrupted bonding was resolved and that his social engagement systems were awakening and coming online with gusto. As previously noted, lack of attachment is far too often attributed to the mother’s perceived lack of availability and attunement. It was Erika’s and Jon’s shared trauma that disrupted their natural rhythm and mutual drive to bond; trauma that displaced the chance of a mother-child reunion. Now that reunion had happened. And the invasive procedures regarding gastric reflux were never needed.

**Sammy:**

**Child's Play**

“You can discover more about a person in an hour of play than in a year of conversation”

– Plato

Often, children’s symptoms or behavioral changes can present puzzling questions that baffle parents and pediatric professionals alike. This is especially true when the child has “good enough” parents who provide a stable and nurturing home environment. Sometimes the child’s new actions, although anything but subtle, are a mystery. The bewildered family might not connect the child’s conduct or other symptoms with the source of his terror. Rather than expressing themselves in easy to comprehend ways, kids frequently show us that they are suffering inside through terribly frustrating ways. They do this through their bodies. They may act “bratty,” clinging to parents or throwing tantrums. Or, they might struggle with agitation, hyperactivity, nightmares or sleeplessness. Even more troubling, they may act out their worries and hurts by “steam-rolling” over a pet or younger, weaker child. For other children, their distress may show up as head and tummy aches or bed-wetting. Or they may avoid people and things they used to enjoy in order to manage unbearable anxiety. Parents ask, where in the world can these childhood symptoms possibly come from? There are often hidden culprits in the day to day physicality of childhood. When unresolved, fairly regular childhood events --- such as falls, accidents and invasive and emergency medical procedures --- become suspects in the case to uncover what underlies a child’s distress.

 Children, by their nature, enjoy play. Therapists and parents can use the vehicle of guided play to help them to rebound and move beyond their fears to gain mastery over their scariest moments. As children express their inner world through play, their bodies are directly communicating with us.

What follows is an example of showing parents (in this case, also a grandparent) how to work with a child that may be traumatized. I believe that this is an invaluable function that therapists can provide to parents and other caregivers so that *they* can prevent traumatic symptoms from occurring in the wake of potentially overwhelming events (Levine & Kline, 2006, 2008).

**The Story of Sammy’s Strange Behaviors**

Here is the case of a 2½ year old boy in which a “play session”, set up by me and defined by a series of 5 principles, led to a reparative experience with a victorious outcome. The principles offered after this case history, provide simple suggestions for therapists, medical professionals and parents. This case is an example of what can happen when an ordinary fall, requiring a visit to the emergency room for stitches, goes awry. It also shows how several months later, Sammy’s terrifying experience was transformed through play into a renewed sense of confidence and joy…

 Sammy had been spending the weekend with his grandparents, where I was their guest. He was being an impossible tyrant, aggressively and relentlessly trying to control his new environment. Nothing pleased him; he displayed a foul temper every waking moment. When he was asleep, he tossed and turned as if wrestling with his bedclothes. This behavior was not entirely unexpected from a 2½ year old whose parents have gone away for the weekend. Children with separation anxiety often act it out. Sammy, however, had always enjoyed visiting his grandparents and this behavior seemed extreme to them. They confided to me that six months earlier, Sammy fell off his high chair and split his chin open. Bleeding heavily, he was taken to the local emergency room. When the nurse came to take his temperature and blood pressure, he was so frightened that she was unable to record his vital signs. This vulnerable little boy was then strapped down in a “pediatric papoose” (a board with flaps and Velcro straps). With his torso and legs immobilized, the only part of his body he could move was his head and neck—which, naturally, he did, as energetically as he could. The doctors responded by tightening the restraint and immobilizing his head with their hands in order to suture his chin. This imprinted him with an overwhelming sense of powerlessness and helplessness.

After this upsetting experience, mom and dad took Sammy out for a hamburger and then to the playground. His mother was very attentive and carefully validated his experience of being scared and hurt. Soon, all seemed forgotten. However, the boy’s overbearing attitude began shortly after this event. Could Sammy’s tantrums and controlling behavior be related to his perceived helplessness from this trauma?

When his parents returned, we agreed to explore whether there might be a traumatic charge still associated with this recent experience. We all gathered in the cabin where I was staying. With parents, grandparents and Sammy watching, I placed his stuffed Pooh Bear on the edge of a chair in such a way that it fell to the floor. Sammy shrieked, bolted for the door and ran across a footbridge and down a narrow path to the creek. Our suspicions were confirmed. His most recent visit to the hospital was neither harmless nor forgotten. Sammy’s behavior told us that this game was potentially overwhelming for him.

Sammy’s parents brought him back from the creek. He clung dearly to his mother as we prepared for another game. We reassured him that we would all be there to help protect Pooh Bear. Again he ran—but this time only into the next room. We followed him in there and waited to see what would happen next. Sammy ran to the bed and hit it with both arms while looking at me expectantly.

“Mad, huh?” I said. He gave me a look that confirmed my question. Interpreting his expression as a go-ahead sign, I put Pooh Bear under a blanket and placed Sammy on the bed next to him.

“Sammy, let’s all help Pooh Bear.”

I held Pooh Bear under the blanket and asked everyone to help free Pooh. Sammy watched with interest but soon got up and ran to his mother. With his arms held tightly around her legs, he said, “Mommy, I’m scared.”[[6]](#footnote-6) Without pressuring him, we waited until Sammy was ready and willing to play the game again. The next time grandma and Pooh Bear were restrained with the blanket together. And this time Sammy actively participated in their rescue. When Pooh Bear was freed, Sammy ran to his mother, clinging even more tightly than before. He began to tremble and shake in fear, and then, dramatically, his chest expanded in a growing sense of excitement and pride.

 *Here we see the transition between traumatic re-enactment and healing play*: The next time Sammy held on to mommy, there was less clinging and more excited jumping. We waited until Sammy was ready to play again. Everyone except Sammy took a turn being rescued with Pooh. Each time, Sammy became more vigorous as he pulled off the blanket and escaped into the safety of his mother’s arms.

 When it was Sammy’s turn to be held under the blanket with Pooh Bear, he became quite agitated and fearful. He ran back to his mother’s arms several times before he was able to accept the ultimate challenge. Bravely, he climbed under the blankets with Pooh while I held the blanket gently down. I watched his eyes grow wide with fear, but only for a moment. Then he grabbed Pooh Bear, shoved the blanket away, and flung himself into his mother’s arms. Sobbing and trembling, he screamed, “Mommy, get me out of here! Mommy, get this off of me!” His startled father told me that these were the same words Sammy screamed while imprisoned in the papoose at the hospital. He remembered this clearly because he had been quite surprised by his son’s ability to make such a direct, well-spoken demand at 2½ years old.

We went through the escape several more times. Each time, Sammy exhibited more power and more triumph. Instead of running fearfully to his mother, he jumped excitedly up and down. With every successful escape, we all clapped and danced together, cheering, “Yeah for Sammy, yeah! yeah! Sammy saved Pooh Bear!” Sammy had achieved mastery over the experience that had shattered him a few months earlier. The trauma-driven, aggressive, foul-tempered behavior used in an attempt to control his environment disappeared. And his “hyperactive” and avoidant behavior during the reworking of his medical trauma was transformed into triumphant play.

**Five Principles to Guide Children’s Play towards Resolution**

The following section includes an analysis of Sammy’s play experience. This will help clarify the outlined principles and support therapists and caregivers in their application.

1. Let the child control the pace of the game.

Healing takes place in a moment-by-moment slowing down of time. In order to help at child feel safe, follow her pace and rhythm. If you “put yourself in the child’s shoes” through careful observation of her behavior, you will learn quickly how to resonate with her. Let’s revisit the story to see exactly how we did that with Sammy:

 By running out of the room when Pooh Bear fell off the chair, Sammy “told” me loud and clear that he was not ready to engage in this new activating “game.” Sammy had to be “rescued” by his parents, comforted, and brought back to the scene before continuing. In order to make him feel safe we all assured him that we would be there to help protect Pooh Bear. By offering this support and reassurance, we helped Sammy move closer to engaging with the game—*in his own time at his own pace*.

After this reassurance, Sammy ran into the bedroom instead of out the door. This was a clear signal that he felt less threatened and more confident of our support. Children might not state verbally whether they want to continue, so take cues from their behavior and responses. Respect their wishes in whatever way they choose to communicate. Children should never be rushed to move through an episode faster or forced to do more than they are willing and able to do. Just like with Sammy, it is important to slow down the process if you notice signs of fear, including: constricted breathing, stiffening, or a dazed (dissociated) demeanor. These reactions will dissipate if you simply wait quietly and patiently while reassuring the child that you are still by their side and on their side. Usually, the youngster’s eyes and breathing pattern will indicate when it’s time to continue.

2. Distinguish between fear, terror and excitement.

Experiencing fear or terror for more than a brief moment during traumatic play will not help the child move through the trauma. Most children will take action to avoid it. Let them! At the same time, try and discern whether it is avoidance or escape. The following is a clear-cut example to help in developing the skill of “reading” when a break is needed and when it’s time to guide the momentum forward.

When Sammy ran down to the creek, he was demonstrating avoidance behavior. In order to resolve his traumatic reaction, Sammy had to feel that he was in control of his actions rather than driven to act by his emotions. Avoidance behavior occurs when fear and terror threaten to overwhelm. With kids, this behavior is usually accompanied by sign(s) of emotional distress (crying, frightened eyes, screaming). Active escape, on the other hand, is exhilarating. Children become excited by their small triumphs and often show pleasure by glowing with smiles, clapping their hands or laughing heartily. Overall, the response is considerably different from avoidance behavior. Excitement is evidence of the child’s successful discharge of emotions that accompanied the original experience. This is positive, desirable and necessary.

Trauma is transformed by changing intolerable feelings and sensations into desirable ones. This can only happen at a level of activation that is similar to the level of activation that led to the traumatic reaction in the first place. If the child appears excited, it is OK to offer encouragement and continue as we did when we clapped and danced with Sammy. However, if the child appears frightened or cowed, give reassurance but don’t encourage any further movement. Instead, be present with your full attention and support, waiting patiently until a substantial amount of the fear subsides. If the child shows signs of fatigue, take a rest break.

3. Take one small step at a time.

You can never move too slowly in renegotiating a traumatic event with anyone; this is especially true with a young child. Traumatic play is repetitious almost by definition. Make use of this cyclical characteristic. The key difference between *“renegotiation”* and traumatic play (re-enactment) is that in renegotiation there are incremental differences in the child’s responses and behaviors in moving towards mastery and resolution. The following illustrates how I noticed these small changes with Sammy:

When Sammy ran into the bedroom instead of out the door, he was responding with a different behavior indicating that progress had been made. No matter how many repetitions it takes, if the child you are helping is responding differently—such as with a slight increase in excitement, with more speech or with more spontaneous movements—he is moving through the trauma. If the child’s responses appear to be moving in the direction of constriction or compulsive repetition, instead of expansion and variety, you may be attempting to renegotiate the event with scenarios which involve too much arousal for the child to make progress. If you notice that your attempts at playful renegotiation are backfiring, ground yourself and pay attention to your sensations until your breathing brings a sense of calm, confidence and spontaneity. Then, slow down the rate of change by breaking the play into smaller increments. This may seem contradictory to what was stated earlier about following the child’s pace. However, attuning to children’s needs sometimes means setting limits to prevent them from getting wound up and collapsing in overwhelm. If the child appears tense or frightened, it’s OK to invite some healing steps. For example, when re-negotiating a medical trauma, you might say, “Let’s see, I wonder what we can do so Pooh Bear (Dolly, GI Joe, etc.) doesn’t get so scared before you (the pretend doctor/nurse) give him the shot?” Often children will come up with creative solutions showing you exactly what *they needed - he missing ingredient* that would have helped them settle more during their experience.

Don’t be concerned about how many times you have to go through what seems to be the “same old thing.” We engaged Sammy in playing the game with Pooh Bear at least ten times. Sammy was able to renegotiate his traumatic responses quickly. Another child in your care might require considerably more time. You don’t need to do it all in one day! Resting and time are needed to help the child internally reorganize her experience at subtle levels. Be assured that if the resolution is not complete, the child will return to a similar phase when given the opportunity to play during the next session.

4. Become a Safe Container.

Remember that biology is on your side. Perhaps the most difficult and important aspect of renegotiating a traumatic event with a child is maintaining your own belief that things will turn out OK. Once held, this feeling of positivity and confidence comes from inside you and is projected out to the child. It becomes a container that surrounds the child with a feeling of confidence. This may be particularly difficult to maintain if the child resists your attempts to renegotiate the trauma.

If the child resists, be patient and reassuring. A deeply instinctive part of the child wants to re-work this experience and become free of it. All you have to do is wait for that part to feel confident and safe enough to assert itself. If you are excessively worried about whether the child’s traumatic reaction can be transformed, you may inadvertently send a conflicting message. Adults with their own unresolved childhood trauma may be particularly susceptible to falling into this trap. Please be kind to yourself.

5. Stop if you feel that your child is genuinely not benefiting from the play.

 In *Too Scared to Cry* (1992), Lenore Terr, the esteemed child psychologist, warns clinicians about allowing children to engage in repetitious traumatic play that reenacts the original horror. She describes the case of three-and-a-half-year-old Lauren who was the victim of sexualised abuse. Here, Lauren is playing with toy cars: “The cars are going on the people,” Lauren says as she zooms two racing cars towards some finger puppets. “They’re pointing their pointy parts into the people. The people are scared. A pointy part will come on their tummies, and in their mouths, and on their ... [she points to her skirt]. My tummy hurts. I don’t want to play anymore.” Lauren stops herself as her bodily sensation of fear abruptly surfaces. This is a typical reaction. She may return over and over to the same play, each time stopping when the fearful sensations in her tummy become uncomfortable. Some therapists would say that Lauren is using her play as an attempt to gain some control over the situation that traumatized her. Her play does resemble “exposure” treatments used routinely to help adults overcome phobias. But Terr cautions that such play ordinarily doesn’t yield much success. Even if it does serve to reduce a child’s distress, this process is quite slow in producing results. Most often, the play is compulsively repeated without resolution. Unresolved, repetitious, traumatic play can reinforce the traumatic impact in the same way that re-enactment and cathartic reliving of traumatic experiences can reinforce trauma in adults.

 The re-working or renegotiation of a traumatic experience, as we saw with Sammy, represents a process that is fundamentally different from traumatic play or re-enactment. Left to their own devices, most children, not unlike Lauren in the above example, will attempt to avoid the traumatic feelings that their play evokes. But with guided play, *Sammy was able to “live his feelings through” by* *gradually and sequentially mastering his fear*. Using this stepwise renegotiation of the traumatic event and Pooh Bear’s companionship, Sammy was able to emerge as the victor and hero. A sense of triumph and heroism almost always signals the successful conclusion of a renegotiated traumatic event. By following Sammy’s lead (after setting up a potentially activating scene), joining in his play, and making the game up as we went along, Sammy got to let go of his fear. In this example, it took minimal direction (30-45 minutes) and support to achieve the *unspoken* goal of aiding Sammy to experience a corrective outcome. In this way, as Sammy’s motoric potentiality changed, so did his embodied perception of the world, from dangerous to safe[[7]](#footnote-7), exciting and inviting.

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1. Pioneering neurophysiologist and winner of the 1981 Nobel Prize for Physiology and Medicine. [↑](#footnote-ref-1)
2. Neurologist and neurosurgeon. [↑](#footnote-ref-2)
3. Procedural memories are impulses, movement or action patterns, that are experienced as body sensations through interoceptive awareness. See: Levine, 2015, p 25. [↑](#footnote-ref-3)
4. In my clinical work, I have observed that children who were born via C-section often have a lack of power when they first attempt standing as toddlers. Then, as mature adults, they often have difficulties initiating actions in the world. [↑](#footnote-ref-4)
5. I believe that Erika’s report demonstrates the formation of pre-logical associational networks (procedural memory engrams), which, remained in place when they returned for a two-year “checkup” at age four and a half. [↑](#footnote-ref-5)
6. This trust of safety would not happen without a solid attachment. Where healthy bonding is not the case, or where there is abuse, therapy is, of course much more complex and also generally involves therapy for the parents or caregivers. [↑](#footnote-ref-6)
7. See Porges.S. and Daniel. S., this volume. [↑](#footnote-ref-7)