CHAPTER 15

Play Therapy with "Children of Fury"

TREATING THE TRAUMA OF BETRAYAL

David A. Crenshaw

Child of Fury

Oh, child of fury how long has it been since someone touched your heart?
Words may fail, but perhaps you can express your pain through play or art.
So many tears locked away inside, untold burdens too heavy to bear;
How long has it been since you shed a tear?
Too long. Too long I say! Let those tears flow.
How long since a hug, a tender touch, or kind words set your heart aglow?
Oh, child of fury play and paint with all your heart, your heart so torn apart.

—David A. Crenshaw

Children of fury are not always able to express in words the rage stemming from the many and varied forms of betrayal they have experienced. The rage may exceed words. However, these children may be able to draw, paint, create pictures in a sandtray, or use clay or puppets to express their fury when words fail. The term *children of fury* is not intended to indicate that these children invariably act out their rage. Rather, the term is meant to describe children who, due to invisible emotional wounds, harbor rage and fury. Under specific conditions, when triggered by certain internal or external events, they act out their fury.

Of all the presenting problems that play therapists are called on to treat, physical aggression tends to cause the most anxiety and stress, with the possible exception of sexualized behavior in the playroom. In addition to the anxiety related to keeping the child and therapist safe in the playroom, typically there are increased pressures from parents, schools, and other referral sources to resolve the problem quickly. The aggressive behavior unnerves parents and school officials, and may threaten the safety of other children. In discussing aggression in childhood, I am mindful of Jerome Kagan's (1998) admonitions to be careful in the language we choose. Although it may create awkwardness at times in wording, I follow, as carefully as possible, his strong recommendation that we as clinicians should never use the phrase *aggressive children*. Kagan explained that no child is aggressive all the time, even the most violent

child. Some children may be aggressive at home but not at school, or vice versa. The child who is aggressive at home will not be aggressive at all times, but is quite likely to become aggressive when his older brothers tease him. The context must be supplied when talking about aggressive behavior in children.

Aggression in children is the result of multiple contributing factors. In his 1998 lecture "How We Become Who We Are" to the Psychotherapy Networker Symposium, Kagan used the analogy of a tapestry woven together in a complex way by many threads. The threads include biological factors (genetics and neurobiology); social influences, including our family and the values we are taught by our families; and our culture and its values; and even the historical moment in time in which we grow up. Children growing up today encounter a markedly different world than the one I experienced in my formative years. In addition to risk factors such as poverty, psychiatric disturbance in the parent(s), substance abuse by parents, child abuse (physical or sexual or both), criminal incarceration of a parent, and neglect (ACES Study; Anda et al., 2006), the other side of the equation also needs to be considered. Children can be remarkably resilient and hardy (Crenshaw, 2013), as illustrated by studies of Ugandan former child soldiers who were exposed and subjected to unimaginable atrocities. Viewing all of these contributing risks and assets, and their interaction with each other, makes for the weaving of a complex tapestry indeed!

Description of the Clinical Application

An Integrative Approach

An integrative approach to working with children of fury has guided my play therapy with children in residential treatment settings who display extreme aggression under specific conditions, and with children in an outpatient private practice for 36 years who exhibited a wide range of aggressive behaviors, again within a specific context.

Child-Centered Play Therapy

Child-centered play therapy (CCPT) is the treatment of choice while working to build a strong therapeutic relationship. The attunement, curious attentiveness, empathy, genuineness, and warmth that CCPT emphasizes leads to trust, growth, and healing in children who present a wide array of problems. CCPT is especially effective when aggression is the presenting problem because many of these children will not easily trust the therapist. CCPT demonstrated positive results with a group of elementary school children (Ray, Chapter 32, this volume; Ray, Blanco, Sullivan, & Holliman, 2009). Children who participated in a 14-session CCPT group demonstrated a significant decrease in aggression, whereas children in a control group showed no significant change in aggression. In an exploratory study of disruptive behavior in a Head Start program, CCPT demonstrated statistically significant decreases in aggression as well as for problems of attention (Bratton et al., 2013).

Disrupted attachment in early life can be a contributor to aggression. CCPT has been shown to increase the child's attachment security with the therapist even when the child remains insecurely attached to the parent (Anderson & Gedo, 2013). In the Anderson and Gedo (2013) case study the child's mother was not able to participate in the therapy due to language barriers; however, the child's level of aggression still decreased as the result of CCPT. A modified CCPT approach used with highly aggressive adolescents has shown promising results as well (Cochran, Fauth, Cochran, Spurgeon, & Pierce, 2010). Cochran and colleagues (2010) viewed the person-centered approach, with its emphasis on warmth, genuineness, and empathy, as particularly well suited for adolescents who are reluctant to engage in a verbal expressive therapy approach.

Sensory–Motor Therapy

Sensory–motor therapy, based on findings from neuroscience, offers exciting new opportunities for working with young children presenting with aggressive behavior. Traditional therapy approaches may fail with children exposed to early trauma unless attention is paid to hyperarousal and the need to soothe the brainstem (Gaskill & Perry, 2014). In an exploratory study with at-risk preschoolers in a therapeutic program, use of the neurosequential model of therapeutics (NMT; Gaskill & Perry, 2014) to determine the timing, nature, and "dose" of therapeutic activities provided in the context of filial play therapy (Barfield, Dobson, Gaskill, & Perry, 2012) resulted in significant improvement in emotional regulation and impulse modulation. The NMT emphasizes that what we do may not be as important as when we do it. NMT is a promising framework to integrate into play therapy to guide play therapists in the timing and sequencing of their interventions based on brain research.

Gestalt Play Therapy

Using a Gestalt play therapy approach, Oaklander (2006) described three phases of dealing with anger in play therapy. The first phase she referred to as "talking about" the angry feelings. This initial work involved not only developing a lexicon for the feelings but also drawing or painting pictures depicting a wide range of angry feelings. She also utilized music, such as the beat of the drum, to help children express various intensities of anger. In the second phase of the anger work, Oaklander focused on new and more satisfying ways of expressing anger. She found that it was important to enlist the family in this phase of the work because the way the family expresses anger can profoundly affect the way the child deals with his or her experiences of anger, ranging from slight annoyance to out-of-control rage. In the third phase, in the safety of the therapeutic relationships Oaklander sought to determine whether there was blocked or buried anger related to unresolved trauma or grief. The anger may be so buried as to be completely out of the child's awareness. This type of anger needs to be released in small increments so it doesn't frighten or overwhelm the child. The Gestalt approach, as best elucidated by Oaklander, has much to offer to play therapists working with problems of aggression and can be integrated with other approaches.

Psychodynamic Play Therapy

With its emphasis on dynamic forces such as unconscious motives, feelings, and impulses, psychodynamic play therapy offers a deep understanding of the child's symbolic play and creative productions whether in sandplay, art and drawing activities, or use of clay or other materials (see Crenshaw & Mordock, 2005a, 2005c; Mordock, Chapter 5, this volume). Psychodynamic theory can also guide different levels of empathic statements and interpretations in response to the symbolized play or creative expressions (Crenshaw & Mordock, 2005a, 2005c).

Key Concepts and Strategies

Identification with the Aggressor

Children brought to play therapy for problems of aggression frequently identify with the aggressor in their aggressive play action, at least in the early stages of the work. This identification is easily understood from a psychodynamic framework. Children who have either witnessed or been subjected 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. The problem arises when children get stuck in the role of aggressor; if this behavior continues indefinitely, it can lead to crystal-

lization of their self-identity around the aggressor. This dynamic is seen in many cases of bullying (see Baron, Chapter 16, in this volume). In the event that the child gets fixated on the role of the aggressor, a directive stance is adopted by the play therapist to help the child shift to other more constructive ways of experiencing power. In some cases, they can be the police chief in the play drama, or the mayor, the judge, or any character through which power can be exercised in constructive, helpful ways. The play therapist may need to be quite active and directive to keep the child from reverting back to identifying with the aggressor. Brief sequences of playing one of the constructive, empowering roles can be useful, followed by praise to help the child to make this shift (credit goes to Kevin O'Connor for his suggestion of this intervention at a workshop I attended in 1995).

Empathy-Based Interventions

Regardless of specific theoretical approaches, it is crucial to include empathy-based interventions. Research has shown repeatedly that the lack of empathy is a hallmark of serious aggression and violence (Andershed, Kerr, Stattin, & Levander, 2002; Kolla et al., 2013). Social skills training and anger management strategies are likely to miss the mark if they don't include empathy-based interventions. Examples of specific empathy-based strategies in both individual and group work are available in previous writing along with descriptions of specific programs developed to increase empathy (see Crenshaw & Mordock, 2005a, 2005c).

Theory and Research

The contributing factors in childhood aggression are many and varied. Profound losses and rage can result from being born into and raised in poverty, growing up in dangerous and crime-filled neighborhoods, and/or being bullied in school. When grief is buried, remaining unexpressed and unresolved, it can turn into anger and ultimately to rage. Some children never develop an adequate sense of empathy due to assaults on their dignity and humanity. To be judged harshly and narrowly because of gender, race, class, ethnic, regional, or national group membership is a dehumanizing experience. Although social toxins (Garbarino, 1999) impact many children, an extremely small percentage become violent offenders as adults (Kolla et al., 2013). Children with limited educational and vocational opportunities, faced with daily threats of violence, may turn to gangs for affiliation and protection needs. Key factors among the small number who becomes violent offenders in adulthood are the callous/unemotional traits associated with the syndrome of psychopathy (Kolla et al., 2013).

Psychopathic individuals tend not to accurately read signs of pain or sadness in others. The personality pattern of psychopathy in adult criminals is associated with an earlier onset of criminal acts compared to other criminals, commission of more violent crimes, and engaging in more violence while incarcerated (Andershed et al., 2002; Decety, Chen, Harenski, & Kiehl, 2013). It is important to hold this perspective in mind because most children seen in clinical practice for aggression or conduct problems are not headed for a life of violent crime, the parents' and sometimes the clinician's fears notwithstanding. What we most frequently encounter in clinical practice is reactive instead of proactive aggression.

Reactive aggression is defined as hostile, impulsive behavior in response to a perceived threat or frustration, in contrast to *proactive aggression*, which entails the commission of aggressive acts that are often unprovoked and directed toward possessing or controlling others (sometimes referred to as *instrumental aggression*; Dodge & Coie, 1987). Reactive aggression—but not proactive aggression—was found to be linked to

childhood maltreatment (Kolla et al., 2013). Although further research is indicated, it appears that psychopathy is a critical contributing factor to the emergence of proactive aggression (Kolla et al., 2013). Again, these findings are important for the play therapist as well as the parents of the children seen in treatment who may be unduly worried that their child of fury is headed for a life of violent crime.

Aggression and destructive behavior before the age of 3 predicts later problems in preadolescence and calls for early recognition and intervention (Pihlakoski et al., 2006). Aggression in childhood can occur in 12-month-olds but was observed more commonly in 24- and 36-month-olds in a nonclinical sample (Alink et al., 2006). The rates of physically aggressive behaviors increased in the second year of life and declined beginning after the third birthday on (Alink et al., 2006).

Conventional wisdom has suggested that the greater aggression seen in young boys, as compared to girls, is the result of the difference in the ways that boys and girls are socialized in our culture. Studies by researchers in Canada (Zoccolillo et al., 2007) found that at just 17 months of age, there was a substantial gender difference in the prevalence of physical aggression, with 5% of the boys but only 1% of the girls exhibiting physically aggressive behavior on a frequent basis. There was no change in this difference at 29 months. Zoccolillo and colleagues (2007) asserted that it is unlikely that differential gender socialization could account for such marked differences at such an early age. This view could be challenged, however, by attachment researchers who have found that there are early differential ways that children present as well as ways we interact with them based on gender (Weinberg, Tronick, Cohn, & Olson, 1999).

Attachment security also plays a role in childhood aggression. Boys with disorganized attachment and children with ambivalent attachment reported a higher level (more frequent and severe) of externalizing problems than did secure children (Moss et al., 2006). Pervasive hyperactivity in preschool boys combined with poor quality of mother–child interactions were predictive of higher rates of aggression and noncompliant or nonsocial behaviors as well as lower rates of peer acceptance than occurred for boys in a comparison group (Keown & Woodward, 2006). Preschool children exposed to cumulative family risk factors (e.g., parental alcoholism, parental depression, antisocial behavior, marital conflict) along with difficult child temperament showed higher levels of aggression at 18 months than children in low-risk families (Edwards, Eiden, Colder, & Leonard, 2006). Boys with high- or low-risk status had higher levels of aggressive behavior at all ages than girls. Media exposure is still another factor. A 2-year longitudinal study found that the extent of media exposure predicted relational aggression for girls and physical aggression for boys at school (Ostrov, Gentile, & Crick, 2006).

Still another factor associated with early childhood aggression is prenatal exposure to cocaine combined with gender and environmental risk factors (Bendersky, Bennett, & Lewis, 2006). Cocaine exposure *in utero* combined with being male and a high-risk environment were all predictive of aggression at the age of 5.

Metaphors to Inform the Rationale for Intervention

Play therapists can't begin to adequately treat children of fury without a cohesive rationale based on theory and research to guide the treatment plan and the choice of interventions. Helpful ways of conceptualizing the problem of aggression in children are described below.

"Fawns in Gorilla Suits"

The metaphorical phrase *fawns in gorilla suits* applies particularly to children in

foster care and especially in residential treatment programs. These children often experience relational trauma at the beginning of life (Schore, 2012) and then are exposed to various social toxins (Hardy & Crenshaw, 2008; Hardy & Laszloffy, 2005) such as poverty, abuse, and neglect, along with discrimination and devaluation due to gender, class, nationality, racial, or heterosexual bias. I've used this metaphor to describe many of the children in child welfare placements (Crenshaw & Garbarino, 2007; Crenshaw & Hardy, 2005; Crenshaw & Mordock, 2005a, 2005b, 2005c) because I think it captures the essential dynamics of children suffering from complex or developmental trauma (van der Kolk, 2005). In addition to the sociocultural trauma (Hardy & Laszloffy, 2005), the children who populate residential treatment centers have experienced a high proportion of adverse childhood experiences (ACES), including physical and/or sexual abuse and/or neglect, family and/or community violence, major psychiatric disorder in one or both parents, incarceration of one or both parents, substance abuse by one or both parents, and separation or divorce of parents (Anda et al., 2006). In an unpublished study (Crenshaw & Alstadt, 2011) in one residential treatment center, 87% of the last 100 children admitted had at least four of these ACES (Anda et al., 2006). In previous studies of ACES, four or more such experiences placed a person at high risk for a range of deleterious behavioral and physical health outcomes (Anda et al., 2006).

Defensive Strategy: The Gorilla Suit

Fawns in gorilla suits typically suffer complex or developmental trauma due to three sources of trauma exposure: (1) relational trauma, (2) sociocultural trauma, and (3) ongoing exposure to ACES. A common shared and repeated experience of our fawns in gorilla suits is the assault on their dignity (Crenshaw & Hardy, 2005; Hardy & Crenshaw, 2008; Hardy & Laszloffy, 2005). The metaphor of the gorilla suit delineates the defensive operations: the gorilla suit represents the identification with the aggressor. The aggression keeps people at a distance and is designed to protect the vulnerable, often traumatized core self that is represented by the fawn. The anger, rage, and aggression are in response to the cumulative trauma rooted in multiple origins and myriad contributing factors identified earlier.

Defensive Strategy: Brick Wall of Detachment

It should be noted that not all youngsters use aggression as a defensive function to protect the traumatized, vulnerable self (fawn). It is also common to encounter children who barricade themselves behind a *brick wall of detachment*. The children using this strategy are nearly impossible to make contact with emotionally. They are remote, unmoved, and impervious to the efforts that therapists make to establish meaningful connections with them. Children who barricade themselves behind the brick wall of detachment tend to respond only to those therapists and adults who refuse to give up on them and persevere in the face of constant obstacles and discouragement.

"Children of Fury"

I have come to realize that although fawns in gorilla suits frequent the populations of children in the foster care system and particularly those placed in residential treatment and inpatient programs, they don't account for all the enraged children that the play therapist might encounter. Play therapists work in a wide range of settings, including inpatient programs, partial hospitals, day treatment centers, outpatient clinics, schools, Head Start centers, prevention programs, and private practice. The children to whom I refer as *children of fury* can

be encountered in any of these settings, and the core psychodynamic issue for these children is intimate betrayal. Of all the experiences encountered in human life, betrayal, perceived or actual, tends to provoke the most intense rage. This experience is sometimes referred to as *betrayal trauma* (Gobin & Freyd, 2013). According to betrayal trauma theory, children who have early experiences of violation and betrayal by close others may not develop certain social capabilities, including the ability to make healthy decisions about whom to trust. As a result, these children become vulnerable to repeated betrayal and the consequent cumulative rage.

The Myriad Forms of Betrayal

The descriptions of intimate forms of betrayal that follow are not comprehensive because such wounds and the accompanying fury can be provoked by both subtle as well as overt actions. The betrayal can be intended or unintended. It is always the subjective experience of betrayal that matters in understanding the fury of the betrayed, not the unassailable facts. For instance, children whose parent abuses alcohol or drugs may have a gratifying connection with the sober/clean parent and feel betrayed and enraged when the intoxicated parent shows up. In contrast, in *betrayal trauma theory* (Freyd, 2008; Freyd & Birrell, 2013)—which focuses on caretakers, upon whom the betrayed person is dependent for survival, who then abuse, neglect, or in some way significantly violate that person's sense of trust—the betrayed person is posited to be numb to reacting to the betrayal. The dependence on the caretakers for survival can "blind" the person to the betrayal (Freyd & Birrell, 2013) and can pose a formidable force in silencing the betrayed victim. Although I have treated clients who would fit the criteria of betrayal trauma, as outlined by Freyd (2008), especially in instances of sexual abuse by a caretaker and when the child is silenced by threats, more often my clinical experience has shown that betrayal is not a silent wound, at least not over time.

I've worked with many families that suffer the extreme stress and hardship of a chronically ill family member. Clinical experience has revealed that no matter how much love is shared in the family, the devastation of chronic illness may be enraging to the other members of the family. The resources of the family are disproportionally allocated to the ill family member, leaving fewer resources in the form of time, energy, money, and activities for the rest of the family. This dramatic change in family life can feel like a betrayal and can provoke wrath in family members who experience this sense of betrayal. Children may experience guilt and shame for having such feelings, thus making it hard to talk about and resolve. The same dynamics apply to the death of a family member. Emotionally, it can feel like desertion and betrayal, even though such feelings cause great distress because of guilt and shame. Rage is often relegated to a secret chamber of the heart that gets unleashed at the most unexpected times.

Children who have been abused or neglected by the very adults who would be expected to love and protect them will almost certainly experience a sense of betrayal. An elementary school student may experience enduring fury as a result of the betrayal of a former best friend who now has joined with other peers to taunt and bully him or her. In middle school and high school it is not unusual for students to feel betrayed by a former boyfriend or girlfriend who has a new romantic interest. Sometimes the fury is directed primarily at the ex-boyfriend or girlfriend and sometimes at the person who is the new romantic partner, the one who has replaced him or her.

Betrayal can take the form of promises broken, especially if this is a pattern. I've often observed the fury of children in foster care whose parent(s) doesn't show for a visit that was promised to the child. The same applies to children of divorce when

promises of regular phone calls or visits by the noncustodial parent are repeatedly broken. Secrets not kept by friends who were previously considered trustworthy can trigger rage that can be the equal to that of a scorned lover. A teacher who humiliates a child in front of the entire class is often perceived by the child as betraying his or her implicit trust.

Abuse, neglect, and betrayal permeate all levels of society and socioeconomic groups. I've encountered children of fury from affluent families. Their parents may occupy positions of occupational prestige or esteemed social status in the community, and they may be extremely generous with their time and talents to local charities and community causes. But the children of fury may feel betrayed. In their rage they sometimes portray their parents as "frauds." They explain that although their parents relentlessly pursue success in ways that are recognized by the larger community, the children feel abandoned, robbed of their parents' time and interest. The rage of these youth is sometimes striking and when introduced into family sessions, it is often shocking to the parents, who have long been oblivious to the needs and feelings of their children.

Of all the betrayals so devastating to children, the worst and the hardest to heal is, in my experience, the ultimate betrayal of a child by a parent. An example that is even hard for most people to imagine is when a parent would choose their romantic partner over the child after that partner had abused the child. Children suffering this ultimate betrayal are often placed out of the home in foster care after intervention by child protective services (Webb, 2007). The fury in these cases is understandably beyond description. The rage can reach homicidal proportions, at least in fantasies about revenge. Sadly, some of these children redirect the rage inward in the form of suicidal attempts or nonsuicidal forms of self-injury. They turn on themselves with the same contempt that the parent has shown to them, and they feel unworthy of love from anyone.

Betrayal by the Play Therapist

Play therapists can make mistakes that trigger the fury of children and leave them feeling betrayed. Children in play therapy often test therapists in a wide range of ways to see if they are trustworthy, dependable, and genuine. Keeping a secure, reliable structure and frame around the play therapy is essential with children and even more important with children of fury who have experienced prior devastating betrayals. For instance, the child will pay close attention to details, such as the therapist's (1) being on time for appointments; (2) sensitively handling and preparing the child for breaks in the treatment due to illness, vacation, or conference attendance; and (3) following up in a concerned way when a child misses an appointment. The child will be watching to see if details of the sessions are indeed kept confidential. He or she will be acutely sensitive to what is shared with parents, the school, teachers, or other referring sources.

Since therapists—like other humans—are imperfect, they will inevitably make mistakes. The point is that, when mistakes are made, it is imperative to honestly admit the failure to the child and work toward repairing the rupture in the therapeutic relationship. Play therapists must realize that with children who have prior histories of repeated betrayal, repair may take considerable time—or may not be possible.

Therapeutic Focus with "Children of Fury": Repair of the Injured Sense of Trust

Since an injured sense of trust is endemic to betrayal, the gradual development of trust in the therapeutic relationship can serve as a powerfully reparative emotional experience (Gobin & Freyd, 2009). Although therapists in the play therapy field come from different theoretical schools and approaches, a common factor in the work is providing a secure attachment relationship in the form of the therapist–child

alliance. In the push to utilize evidence-based treatment, nothing is more empirically supported than the quality of the therapeutic relationship (Stewart & Echterling, 2014). In the search for "breakthrough techniques," it can be lost that one of the most potent factors in therapeutic change is the quality of the treatment relationship. If children feel secure and safe in their relationship with the play therapist and experience the therapist as trustworthy, it will be a major step toward healing the damaged sense of trust, an important emotionally corrective experience (Alexander, 1961). When a child of fury reaches a point of sufficient trust and safety with the play therapist, he or she will begin to play out, and perhaps later tell in words, to the extent possible, the story of his or her prior betrayal(s) that has underpinned the rage. When youth begin to disclose and unburden the sources of their rage, it represents "an active declaration of trust" (Bonime, 1989) that is a vital ingredient of healing for those who have suffered the intimate wound of betrayal.

"Surviving the Rage"

A valued colleague of mine, Heather Butt, introduced me to this concept of "surviving the rage," inspired by the work of Winnicott. In order to help children and adolescents of fury, as play therapists we must be able to survive their rage. We must be able to be in the presence of rage that can reach proportions that can be frightening for both the child and the therapist and somehow remain in relationship through the process. Surviving the rage is an enormous challenge. Typically the child is in treatment because a number of key people have not been able to survive the rage. If the child is unable to express the fury and process it in therapy, where is he or she to turn? It may be extremely uncomfortable for the child if, in a fit of rage, he or she breaks one of the toys in the therapy room. In fury the child may try to break windows or smash lights in the room by throwing blocks. Obviously, this behavior calls for effective limit setting and preventive measures to keep both child and therapist safe. But the essential ingredient of surviving the rage is that the therapeutic relationship remains intact. The child learns that his or her fury does not destroy the therapist or totally consume or sweep away the child.

Even if the child doesn't deliberately break toys or furnishings in the playroom, it can be extremely distressing to witness him or her slam dolls on the edge of a table with such force that their heads come flying off. Witnessing rage of sadistic proportions can be disturbing; however, if the rage is contained in the realm of symbolic reenactment, it is far superior to behavioral reenactments in daily life that may lead to harm of self or others. It is important for the therapist to remember that this kind of rage does not arise in a vacuum and that there simply is no rage like the fury that results from betrayal and especially repeated betrayals. To have a once-trusted person be the source of pain adds aggravated insult to the injury.

Surviving the rage is another example of an emotionally corrective experience stemming from the quality and trustworthiness of the therapeutic relationship. Safety is established in play therapy not only by consistently setting limits on unsafe behaviors but also by teaching calming and soothing techniques. These techniques, which include mindfulness training and breathing practices, can be employed when the child is about to spin out of control and is unable to regulate the rage; they also help the child develop an awareness of these emotional states. Perhaps most importantly, safety is established in play therapy by building a strong and trusting relationship with the child. Psychological safety in the therapeutic relationship calms the anxiety of the child and makes it possible for him or her to undertake the arduous process of confronting their invisible wounds.

Honor the "Fighting Spirit"

Play therapists should not overlook the resilience and irrepressible spirit of a child of fury. This is a child who has not given up. She is fighting for her dignity. He feels there is something worth fighting for and defending. She is seeking redress of an intimate, searing wound. This impressive show of strength in the form of fury and outrage can be harnessed and redirected in the form of determination to take effective action to restore dignity in ways that are constructive and helpful. Redirecting the fury will only happen when the invisible wounds and the corresponding rage have been validated and the youth feels understood. Strictly cognitive interventions will fall short because the corresponding affect of the child will need to be expressed and met with empathy.

Respect and Dignity

The essential corrective emotional experience mediated by the therapeutic relationship with children of fury is predicated on treating those children with respect and dignity throughout the treatment process. Children of fury are inordinately sensitive to any offense—perceived or real—to their sense of dignity. Answering the phone during a session with such a youngster, keeping him or her waiting without a sincere apology, or failing to be fully present and attuned will stymie the therapeutic process because in the eyes of the child of fury, these are examples of significant ruptures in the attachment with the therapist.

Clinical Case Example

Background

Manny (fictitious name), a child of fury, was 8 years old when I met him for the first time. A Hispanic child, Manny was adopted by spouses who were both elementary school teachers. In Manny's view, the first betrayal occurred when his birth mother made him available for adoption because she was young and poor. She didn't feel she could give him a decent life and the father, who was also young, was not able and/or willing to help. The father was no longer in a relationship with his mother.

Manny's adoptive parents were well-intended people who had raised three children of their own and wanted to raise another child when their youngest son was a junior in high school. All three of the biological children finished college and were independent at the time Manny began treatment with me. Their oldest son is a coach in high school, their daughter works as a paralegal in a law office, and their youngest son is an engineer. All three of the biological children were supportive of Manny and their parents, although the older two expressed concern when the parents, who were well into their 40s, shared their plans for adopting a child. They worried that the parents would not have the energy to deal with the new child, especially if the child had special needs or behavior problems. In spite of the support from the family's grown children, Manny was convinced that the older children didn't accept him into the family (perceived betrayal #2), but he also believed that they would not admit to it. Manny retaliated by being aggressive toward the young children of the oldest son and the daughter when they visited their parents, which made the parents and grandparents wary and frustrated, and further reinforced Manny's belief that he was unwelcome and unwanted in their eyes. In Manny's perception, the grandchildren of his adoptive parents were preferred not only by their parents but by the grandparents (his adoptive parents) over him (subjective betrayal #3).

Manny embarrassed his adoptive parents by acting out in the school where both parents were teachers. He was frequently in the principal's office for aggressive and rough play on the playground and in the lunchroom. If he wanted to sit at a particu-

lar table next to a friend, he would push a child out of the seat in order to sit there. Manny was a hazard to other children on the playground because he would, at times, run recklessly at full speed across the play area and crash into other children, knocking them to the ground, in some cases causing minor injuries. Parents of the other children in his class became alarmed, complained to the principal, and demanded that something be done about Manny.

At other times, Manny could be quite charming. He had a nice smile and could be polite and engaging when he was in a positive mood. But Manny was predominantly a brooding, sulking, and quick-to-anger child. What was most concerning to both the school and the parents were his rages, which frightened other children at school and alarmed the adults. The rages occurred only twice a month or so, but when the fury was unleashed, it was disturbing in both intensity and duration. On some occasions it was necessary for the teacher, the principal, the behavior specialist, and sometimes the school psychologist to restrain Manny by using physical holds (they had received training for this method) to keep Manny and the other children, as well as the school staff, safe. The restraints invariably intensified Manny's fury and undoubtedly extended the duration of the episode, sometimes lasting over an hour. These physical restraints were upsetting to Manny, the school staff, and the other children, resulting in a sense of great urgency when Manny began treatment with me. In Manny's perception, teachers liked the other children in his class far better than him. In accordance with this belief, he acted in such a way to alienate both his teachers and the other students (perceived betrayal #4).

An Integrated Play Therapy Approach

An integrated play therapy approach is illustrated in the work with Manny, beginning with the use of CCPT to build a strong relationship. In addition to needed limits and boundaries to maintain safety, I used the early sessions to follow Manny's lead as he played out numerous battles in puppet play, sandtherapy creations and enactments, and in the family playhouse.

Gestalt play therapy and specifically the work of Violet Oaklander (2006) informed the use of directive interventions, as described below. Psychodynamic play therapy informed the therapist's understanding of the emotional processes underlying Manny's play (Crenshaw & Mordock, 2005a). Sensory-based play activities (Gaskill & Perry, 2014) were utilized throughout the therapy to calm the brainstem and enable Manny to process the therapeutic experience utilizing higher cortical regions of the brain and to maintain appropriate emotional regulation to assist with safety.

My work with fury and rage in play therapy has led me to propose a developmental progression in the expression of aggression through play in the course of therapy in the form of three stages: (1) enactment of the rage, (2) displacement of the aggressive action play into symbolization, and (3) mastery of the rage through symbolic play. The three stages of working through the fury and rage with Manny are described below.

Stage 1: Enactment of the Rage

Manny's sandtray pictures of the world often expressed a degree of fury that was extreme and at times reached sadistic proportions. In a directive intervention with puppets, I took the alligator puppet and asked him to view it as a symbol of what makes him angry and to talk to the alligator about what infuriates him. He immediately grabbed a plastic whiffle ball bat and started pounding the alligator puppet with such force that I had to remove it from my hand to avoid injury. After placing the puppet on the floor, I asked him to try to use words, and in response he started screaming, "You bastard, I hate your guts!" as he continued to pound the alligator puppet with the bat, using all the force he could

muster. I asked Manny if the alligator puppet represented a specific person or situation that caused him such fury. He did not answer but continued to swing the bat at the alligator puppet and screamed loudly, "I hope you rot in hell, you bastard!" The identification with the aggressor was infused with palpable affect.

In the sandtray, Manny's pictures of the world consisted of violent scenes designed to show how overpowering force always wins: Tanks and jet fighters completely decimated villages and towns in a reign of destruction and terror. Manny referred to this obliterating force as "shock and awe" (the battle cry of the U.S. invasion of Iraq in 2003). The bombardments and tank fire continued long after all the buildings were destroyed and all the people had been killed.

This extreme intensity of rage is frequently seen with fawns in gorilla suits and sometimes children of fury. The difference I observe between the two is the directly expressed affect versus the symbolized affect. Fawns in gorilla suits at times manifest minimal overt affect even though it is vividly symbolized. Children of fury almost always express intense, overt affect in keeping with the aggressive and sometimes violent action of the play. They tend to be extremely animated and loud, and I've often had my sessions with a child of fury interrupted by a knock on the door from a concerned colleague just checking to make sure everyone was okay. In Manny's case, there were multiple knocks on the door, sometimes in the same session, to make sure the occupants had survived the fierce battles. The emotional intensity of these sessions continued over a 3-month period. The symbol of betrayal Manny used in his puppet play was the alligator, whereas in the sandtray he used either the snake or the dragon. These symbols of betrayal were viciously attacked when they appeared in Stage 1 of the work.

Although fawns in gorilla suits are inclined toward aggressive actions in play, they do not consistently register overtly the degree of outrage displayed by children of fury. Partly this difference relates to the central dynamic of betrayal and its accompanying rage in children of fury, whereas fawns in gorilla suits have experienced a whole range of trauma conditions characteristic of complex trauma. The outrage and indignation are no longer as spirited as they once were in the "fawns."

Stage 2: Displacement of Aggressive Action Play into Symbolization

As the intensity of the rage diminished in Stage 2, Manny's symbols of betrayal appeared less frequently and when they did, they typically were attacked but not with the same viciousness observed earlier. It should be noted that these stages aren't linear. The child can show decreasing intensity accompanied by increased symbolization and then be triggered by a memory or an event that forcefully reminds him or her of the betrayal and abruptly moves the child back to Stage 1: enactment of the rage.

Also in this stage, Manny was less invested in his identification with the aggressor role. In addition, increasing use of symbolization was indicated by his elaborate preparation for battles that took the form of "staging the war" in artistic and creative ways. If the battle occurred at all, it tended to be toward the end of the session and enacted with much less intensity than in Stage 1. Another shift common to Stage 2 in my clinical experience was Manny's greater flexibility in response to my participation and input. For example, at one point I suggested the possibility of a peace negotiation. Such a suggestion would have been rejected vigorously in Stage 1, but Manny was open to trying it in this phase of the work (even though the peace talks failed).

Stage 3: Mastery of the Rage through Symbolic Play

In Stage 3 of Manny's therapy the symbols of betrayal in puppet dramas and in the

sandtray gradually disappeared altogether. Aggression faded and gave way to still greater interest in the creative and symbolic containment of his aggression through battlefield design and strategic planning of the battles. His arrangements of the armies were so creative and impressive that he requested that I take pictures of his various colorful battlefield scenes and print them out. Also there was a corresponding decrease of aggressive behavior both at home and school.

Manny never came out of metaphor to talk directly about the injuries to his sense of trust by his perceived multiple betrayals. Like numerous other children his age, Manny needed the safe haven and face-saving cover provided by the symbolic play and the depiction through symbols and pictures to work through and resolve his invisible intimate injuries. When he reached the stage of *mastery through symbolic play*, he gradually became less and less interested in the play that previously had drawn him like a magnet each session to the puppet theatre, the family playhouse, or the sandtray. Manny knew his work was done and so did his family because instead of looking forward to his play sessions, Manny had to be encouraged to go. In addition to mastery of his invisible wounds and a contained symbolic expression of his aggression, the relationship primarily with his adoptive family but also with his therapist had increased his attachment security. This enhanced sense of relational security enabled him to develop a new social map in which there were at least some people in his relational world who could be trusted and who he no longer automatically assumed would betray him. A major part of the corrective emotional experience via the therapeutic relationship was the "survival of the rage."

Conclusion

In this chapter, the metaphor of *children of fury* is introduced to characterize a subpopulation of enraged children and is contrasted with my previous metaphorical description of *fawns in gorilla suits* as another subcategory. Children of fury can be encountered in virtually all the settings in which the play therapist works and are characterized not only by the intensity of their rage but by the core dynamic of perceived betrayal. In contrast, fawns in gorilla suits are primarily encountered in residential treatment centers and inpatient settings and most often have suffered repeated trauma that is now often called *complex trauma*. Also in this chapter, three stages of play therapy with children of fury were described: (1) enactment of the rage, (2) displacement of the action play into symbolization, and (3) mastery of the rage through symbolized play. An integrated play therapy approach was illustrated in a case study with a "child of fury."

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