Why Children Clam Up in Therapy

Cathy A. Malchiodi
David A. Crenshaw

Children do not always start to verbalize their issues and concerns immediately upon arriving at our offices. While most practitioners understand child development well enough to appreciate this fact, they still may expect children to verbally respond to requests to talk. This often takes the form of asking young clients too many questions instead of allowing them to tell their stories in more child-friendly ways. This response can inadvertently stall the therapeutic process with children who might otherwise share their stories through play-based communication or express their narratives through creativity and imagination.

Clinical experience has taught us children actually long to unburden themselves of disquieting secrets, painful life experiences, hurtful relationships, and traumatic events. They will not talk to us, however, unless the therapeutic context and, more important, the helping relationship is safe, inviting, and comfortable. To this end, the authors in this book describe the variety of reasons why and situations in which children "clam up"—a colloquialism that refers to an individual's silence, often in response to a request to disclose information. According to this definition, one may clam up when nervous, embarrassed, or simply because one does not want to talk about a particular subject, event, or feeling. Crenshaw (2008) notes that children in particular often "hit a wall" for a variety of reasons when asked to talk about their feelings or worries in individual, group, or family therapy. In that moment, the

helping professional suddenly is forced to reframe the focus of therapeutic interactions, allow the child to "save face," and discover other ways to help a young client participate in meaningful, productive ways. Most therapists will agree that this is one of the most common challenges in treatment and one that requires specific strategies to not only support a child's sense of safety, but also to establish a relationship that facilitates the child's trust in the recovery process. Another basic necessity is the therapist's way of being with the child or adolescent that conveys the kind of acceptance, warmth, and caring that frees the child to communicate. The therapist also creates a therapeutic space (context) that is engaging, disarming, enveloped in safety, and invites attachment.

Each chapter in this volume provides clinical illustrations of why children may be unable to verbalize during treatment. For example, some are due to strictly developmental issues dependent on a child's age, physical challenges, or cognitive capacities that make words difficult. Other chapters describe children who may struggle with anxiety, fear, or resentment and are unable to verbally articulate emotions or perceptions; for those who have experienced one or more traumatic events, language may be inhibited by a flood of trauma-related memories, avoidance responses, or psychic numbing.

In this chapter, we introduce readers to the central premises of this book and, in particular, why children clam up during treatment. We also establish a foundation to explain how a variety of nonverbal approaches, including play therapy, creative arts therapies, and action-oriented approaches and strategies facilitate effective therapeutic intervention with children who find verbal communication difficult or challenging. Finally, the key characteristics of play therapy and creative arts therapies are explained as essential ways to help children externalize their stories and support verbal narratives.

WHY CHILDREN CLAM UP

There are numerous reasons why children clam up in therapy. Developmental factors such as the child's age, cognitive abilities, and physical challenges may affect if or when a child shares verbal narratives during treatment. For very young children, language is not usually the primary mode for expressing stories or relating life experiences. In addition, temperament can influence the style of a child's communication. Many children, especially during initial therapy sessions, are naturally shy, introverted, or reticent to speak to the therapist until trust and a level of comfort are achieved, efficacy is internalized, and young clients perceive a supportive relationship. While a preference not to speak may be due

to many reasons, recent studies indicate that a significant proportion of older children actually describe themselves as "shy," underscoring that disposition and temperament actually span a wide range of "normal" (Burstein, Ameli-Grillon, & Merikangas, 2011).

Culture may also be a factor in children's preferences for verbal communication. Self-expression in therapy may be inhibited by differences in verbal and nonverbal communication in cross-cultural therapy (Sue & Sue, 1977) in addition to the language barrier itself. Also, differences in class-bound values and cultural values may serve as formidable barriers to free and natural communication between children and their therapist (Sue & Sue, 1977). Sue (2015) strongly asserts that "any system of therapy is by its nature ethnocentric or more accurately culture-specific" (p. 361). Therapy is a form of cultural oppression, as Sue (2015) persuasively argues, because it is derived from traditional white Western European psychological thought; whenever we impose a sociocultural-dominant form of therapy on a diverse client population the therapy itself can be a form of silencing. If, for example, we are treating an African American inner-city boy who expresses what Hardy and Laszloffy (2005) describe as a "survival orientation" in his thinking, empirically supported protocols may call for challenging the logic of such thinking, even if the behavior is adaptive to the youth's circumstances and survival. The dominant medical model, with its emphasis on pathology, has led to a narrow focus that often ignores the complexity of human beings, including their strengths and resilience. Such culturally specific forms of therapy, to the extent that they occupy a position of sociopolitical power, can silence other forms of healing, such as non-Western, indigenous practices that emphasize rituals and community participation.

Children are also reluctant to come to treatment and, in many cases, were brought by parents who felt pressured to seek intervention. Most often, however, children seen in treatment are unable or decline to speak for the specific problems that bring them into treatment in the first place—life experiences that are distressing, challenging, and even traumatic. These experiences may leave them emotionally vulnerable, preferring not to talk about the very events that create fears, worries, and sadness. Children who have experienced multiple disruptive events such as neglect, abuse, or insecure attachment may not have experienced positive conditions necessary for not only language development, but also trust in caregivers and helping professionals. In addition, children who have been exposed to interpersonal violence may not want to talk because they must maintain secrecy about abuse or violence in order to feel safe and survive (Malchiodi, 1997, 2014). With these young clients, an offhand comment, a disapproving facial expression, or even a

stern tone of voice can trigger a cascade of physiological stress responses that are not under voluntary or conscious control. For example, sexually traumatized adolescents may suddenly break eye contact, look down at the floor, purse their lips, and contort their faces, revealing the bodily agony that such focus precipitates when the discussion centers on past trauma events. It is not because they are unwilling to communicate; instead, physiological defense systems (polyvagal system; see Gray & Porges, Chapter 6, this volume, for more information) have hijacked the ability to communicate and socially engage. In addition, in cases of interpersonal violence, and particularly sexual abuse, a "culture of silence" is established in child survivors (Caprioli & Crenshaw, 2015; see Caprioli & Crenshaw, Chapter 9, this volume, for more information). In brief, this silencing not only originates with family systems and communities, it also is reinforced by criminal justice and court systems that purport to help child victims and, as a result, can challenge even the most skilled therapists.

It also is essential that helping professionals accept children's reticence to talk as a normal response to what are often a series of abnormal experiences they are struggling to repair and master. These responses within the context of therapy are not necessarily statements of dysfunction, but rather expressions of "adaptive coping"; when we view children through a trauma-informed lens (see Malchiodi, Chapter 10, this volume, for more information), we immediately begin to accept their resistance, silence, and avoidance of communication simply as reactions that have helped them to survive. In other words, each child responds to stressful situations, including therapy, with personalized strategies for coping and a preference to remain quiet until ready to speak. Just as there are children who eagerly engage with helping professionals, there are children who do not and whose silence is, in effect, a call for help. They may not speak out of fear, anxiety, or even secrecy; others simply may have given up on talking with adults because they have been hurt or abused by caregivers in the past. For some, years of chronic trauma may have left them psychically numb or with somatic reactions ranging from hyperactivation to dissociation when confronted with questions about "what happened." Others may experience what is often referred to as "speechless terror"—the brain's adaptive mechanism that literally shuts down language when sensory memories of terrifying experiences emerge (van der Kolk, 2014). In all cases, these children demand that we address their reactions through channels other than words alone; in brief, intervention must support alternative pathways for communication, while reinforcing a sense of safety and supportive social engagement that helps these young clients self-regulate and trust the therapeutic alliance.

Contributions during the last two decades of neurobiological research have greatly enhanced our ability to understand and explain what is happening in the brain and body when children are unable to speak. In addition to neurobiology, children's reticence to speak can also be framed through humanistic language and concepts. For example, "social maps" (Garbarino & Crenshaw, 2008) reflect the cumulative experience in the child's social world and highly influences expectations of future experiences. If children grow up securely attached to their primary caregivers, their needs are reasonably met, and they are protected and well cared for, their social maps will include beliefs that the world is a safe place and people are trustworthy and dependable. If, on the contrary, children are not securely attached because caretakers have been unpredictable and unreliable, and they have been exposed to violence and abuse, their social maps will reflect their experience in their social world: beliefs that there is no safety, no one to turn to for protection and support, and a lack of people who can be trusted. A child with this social map would be expected to be guarded and mistrustful in approaching therapy, whereas a child with more secure experiences would more easily see the therapist as trustworthy and the therapy space as safe.

PLAYING AND CREATING: EXPRESSING THE UNSPEAKABLE

Helping professionals often encounter children whose experiences are difficult to express with words; many of these events and memories are terrifying for some. When confronted with horror and brutality, play and creative imagination in childhood can come to a halt; fortunately, this is not always the case, and even under extreme conditions, children often are still able to communicate their stories through action-oriented, sensory-based expression. During the Holocaust, for example, some children played in the shadows of crematoriums or on their way to the gas chambers (Eisen, 1988). In camps like Theresienstadt, young people drew and painted images of tremendous beauty and hope under the guidance of sensitive and supportive adults (Goldman-Rubin, 2000). In all cases, these remarkable individuals used play and creative imagination to cope with the terrifying conditions that surrounded them in the face of imminent death (Eisen, 1988; Volavkova, 1978).

Barring the most inhumane and extreme conditions even in war-torn countries, children consistently seek mastery, relief, and compensation through play and creativity; they express the hurts they experience in startling dimensions and expressions beyond what words can convey. While children may attempt to hide their pain from helping

professionals, their hurts ask us to offer them alternative possibilities for communication rather than traditional talk therapy. We also are challenged to meet these children "where they are," respecting the pace of intervention to support safety and trust in the therapeutic relationship. In fact, we often need to not only encourage these children to speak, but also offer options for silent refuge at certain key moments.

In summary, there are many factors that can shut down young people's verbal communication in therapy, including cultural, neurobiological, psychodynamic, and trauma-related effects. When children clam up in the face of these, it is clear that the term "resistance" does not begin to capture the complexity of the contributing influences and contextual features. Both trauma and hyperarousal related to trauma can hijack an individual's ability to communicate. Therapy that is neither culture specific nor sensitive may also inhibit verbal communication in addition to the well-known psychodynamic factors creating conflict and ambivalence about verbal disclosure. When children cannot tell their story in words, even those as young as three can express their inner worlds through play, art, sandtray creations, or other creative arts depictions. The uncanny ability of these children to share their narratives through play, art, music, drama or with miniature figures in a sandtray underscores both the value of right-hemisphere, implicit communication in therapy and the innate self-reparative capacities of these creative modalities. The following sections provide an overview of these approaches, underscoring how each creatively facilitates communication and expands the possibilities for self-expression within the context of therapy.

PLAY THERAPY

Play therapy is defined as the systematic use of play to help individuals prevent or resolve psychosocial difficulties and achieve optimal growth and development (Webb, 2007; Landreth, 2012) and employs a variety of theoretical orientations, including child-centered, Jungian, Adlerian, and others (Crenshaw & Stewart, 2015). It is nearly as old as the field of psychotherapy itself and is generally used with children, but also with families (Gil, 2015a). More recently, play therapy theory has incorporated emphasis on attachment research and neurobiology (Malchiodi & Crenshaw, 2014). Play therapists use a wide range of creative interventions that include toys, props, games, sandplay, and expressive arts and is very similar in theory and approach to that of arts-based therapists who apply many forms of creative intervention in their work. For example, a play therapist may invite a child to engage in painting or work

with clay and then facilitate role play or storytelling through puppets, provide imaginative props, or encourage the use of toy miniatures in a sandbox.

Play is a precursor to creative expression and exploration. Developmentally, play exists before formal artistic expression; in the earliest months of life, infants learn play through rhythm and tempo, social interactions with others through body language and sounds, and experiences like "peek-a-boo" and other sensory-based relationships with caregivers. These experiences, combined with development of cognitive and motor skills, make it possible for children to engage not only in imaginative play, but also in drawing, music making, movement, and pretend activities later on.

Play therapy creates opportunities for children to express untold stories, burdensome secrets, agonizing conflicts, and terror and traumatic events. The setting in which play therapy takes place, the playroom, is an environment that appeals to children, furnished with toys, puppets, sandtrays and miniatures, art supplies, drawing tables, and family playhouses. Play is natural to children and allays anxiety. Therapeutic play allows children to regulate the pace of confrontation with painful material; this is especially true in child-centered play therapy, but all forms of play therapy aim to keep the therapy process safe for the child, and sensitive timing and pacing is the key to that end. Intrinsic qualities of play, such as displacement from action and impulse into symbolic expression, allows the child to gradually approach the most sensitive and painful parts of what hurts internally or within their relational world.

Finally, play is a form of what Schore (2012) describes as right-hemispheric communication that holds the key to emotional regulation. Schore underscores how emotion dysregulation is central to virtually every psychiatric disorder, and action-oriented approaches that include play can help to address this dysregulation in ways that words alone cannot. Play therapy, therefore, occupies a place of great importance in contemporary psychotherapy with children as a result of the interpersonal neurobiological approach elucidated by Perry (2009, 2015), Schore (2003a, 2003b, 2012), and Siegel (1999, 2012).

CREATIVE ARTS THERAPIES

Like play therapy, creative arts therapies can help children bypass the limitations of language as well as expand possibilities for reparative communication through approaches that at least temporarily bypass language (Malchiodi & Crenshaw, 2014). The creative arts (visual art, music, movement, and drama) have an extensively documented and long

history of use in self-expression, self-regulation, reparation, and commemoration, with numerous references throughout medicine, anthropology, and the arts to the earliest healing applications of these forms of communication (Malchiodi, 2005, 2015). Specifically, the creative arts therapies are defined as purposeful individual applications of art therapy, music therapy, dance/movement therapy, drama therapy and poetry therapy within a psychotherapeutic framework (Malchiodi, 2007; National Coalition of Creative Arts Therapies Associations [NCCATA], 2016). Expressive arts therapy is defined as the integrative use of creative arts in therapeutic work (Estrella, 2005; McNiff, 2009; Rogers, 2000). The expressive arts therapy approach is generally understood as using more than one art form, consecutively or in combination, although depending on individual or group goals, one art form may dominate a session. In addition, some practitioners use the phrases *integrated arts* or *intermodal therapy* (also known as multimodal) to describe the use of two or more expressive therapies an individual or group session. Because this approach is defined as integrative, intervention is focused on the interrelatedness of the arts with children.

In work with children, several creative arts therapies are often applied individually, within the context of expressive arts therapy or within the use of play therapy. We outline these below.

Art Therapy

Art therapy is the purposeful use of visual art materials and media in intervention, counseling, psychotherapy, and rehabilitation; it is used with individuals of all ages, families, and groups. Within the applications of art therapy, there is a continuum of practice ranging from art as therapy (art making as a reparative, life-enhancing activity; Malchiodi, 2007; McNiff, 2009) to art psychotherapy (the purposeful, integrative application of art-based intervention within a variety of psychotherapeutic and counseling approaches; Malchiodi, 2013). With children, art expression can be both a means of self-regulation as well as symbolic communication of personal stories and worldviews.

Music Therapy

Music therapy uses music to effect positive changes in the psychological, physical, cognitive, or social functioning of individuals with health, behavioral, social, emotional, or educational challenges (Wheeler, 2015). In general, music therapy is applied to work with young clients for affect regulation and communication and to support behavioral and interpersonal goals.

Drama Therapy

Drama therapy is an active, experiential approach to facilitating change through storytelling, projective play, purposeful improvisation, and performance (Johnson, 2009). This active approach helps individuals tell their stories to resolve problems, achieve catharsis, extend the depth of inner experience, and strengthen the ability to understand the self and others. In the context of work with children, applications may include imaginative and play-based uses of toys, props, and puppets to express narratives and communicate symbolic content.

Dance/Movement Therapy

Dance/movement therapy is based on the assumption that the body and mind are interrelated and is defined as the psychotherapeutic use of movement as a process that furthers the emotional, cognitive, and physical integration of the individual and influences changes in feelings, cognition, physical functioning, and behavior (Chaiklin & Wengrower, 2016). With children, dance/movement is used to address a variety of interpersonal, emotional, behavioral, and developmental goals; because it is a dynamic approach, it generally includes the use of music, props, and group processes to achieve therapeutic objectives.

Perry (2015) summarizes the power of both creative arts therapies and play therapy from a modern-day, neurobiology-informed perspective:

> Amid the current pressure for 'evidence-based practice' parameters, we should remind ourselves that the most powerful evidence is that which comes from hundreds of separate cultures across the thousands of generations independently converging on rhythm, touch, storytelling, and reconnection to community . . . as the core ingredients to coping and healing from trauma. (p. xii)

For children, creative expression also serves as a nonverbal means for "breaking the silence" (Malchiodi, 1997) and as a means of "telling without talking" (Malchiodi, 2015) for those who cannot speak publicly about their experiences for various reasons.

PLAY THERAPY AND CREATIVE ARTS THERAPY: POWERFUL PARTNERS IN HELPING CHILDREN COMMUNICATE

There are many reasons play therapy and creative arts therapies are part of the spectrum of recommended practices when addressing children

who clam up in therapy. In brief, there are several unique characteristics of these approaches that not only support psychosocial outcomes within therapy, but also stimulate both nonverbal communication as well as language. The following list summarizes the major reasons why these approaches are helpful and effective in work with children who may not be able to communicate their experiences with words alone.

Empowerment

Both play and creative arts therapies are, by their nature, experiences that support empowerment, mastery, and self-efficacy. They stimulate active engagement in the moment and are especially helpful to children who may have been passive victims of toxic circumstances such as abuse, neglect, or interpersonal violence.

Externalization

When children externalize their internal thoughts, feelings, and images, something important happens in terms of mastery. Children reveal compelling facets of their inner world when they play out a drama with puppets, make a picture in a sandtray, draw or paint a picture, create a figure out of clay, or create a play scene in a family playhouse. What gets externalized is experienced as more manageable than what remains internalized. Perry (2015) observes that the fact that the arts, play, and other forms of nonverbal expression are used universally in cultures around the world is significant and underscores their role in health and wellness. There is also evidence that nonverbal expression via action-oriented, sensory-based approaches such as the creative arts may also actually stimulate narrative, thus perhaps reconnecting explicit (story and language) with implicit (sensory) aspects of trauma (Malchiodi, 2013).

Symbol and Metaphor

Both play therapy and art therapy are forms of metaphoric and symbolic communication for children. Because children may seek mastery through play and creative expression when emotions or experiences are overwhelming, these modalities support safe communication through a personal and often idiosyncratic symbolic and metaphoric language. For example, symbolism may be disguised to the degree necessary to allow a child to engage safely in repeated attempts at mastery without getting overwhelmed or disrupted by anxiety. Because children can control play and art making, they remain in control of the timing and pacing of these processes. The child also determines the degree to which the symbolic representation is distant from the actual experience(s). Posttraumatic

play (Gil, 2015b) and posttraumatic art expression (Malchiodi, 2014) are also indications of continuing attempts at mastery stemming from the powerful drive to heal and recover from adversity that we call resilience.

Miniaturization

Play therapy and creative arts therapies share in common the offering of opportunities to children to work with their "big problems" that can be experienced as overwhelming in a miniature, more manageable form. For example, working with puppets, putting miniatures in the sand to make a picture, or drawing people or scenes essentially "shrinks" the problem down to a more workable and manageable level for children that enables them to gain mastery.

Playfulness

Play and creative activities are inherently disarming and allay anxiety, enabling children to engage wholeheartedly in mastery, imaginative, and symbolic communication. Play, for example, "takes us out of time's arrow, allows us to exist in a separate 'state' of being from all others . . . but still is a process of being and doing something just for its own sake" (Brown, 2015, p. xi). In brief, play and creative activities can be experiences of joy, possibility, and transformative, yet playful expression.

Containment

Children, as Terr (1983) pointed out, tend to play out or act out their traumatic experiences. We modify the statement, underscoring that children will play, draw, paint, drum, or dance out their most painful experiences including trauma or they will engage in behavioral enactments of these events. There are important advantages to containing the trauma events in symbolic forms of communication rather than a child acting out, for example, sexualized or assaultive behaviors. In other words, containment through play or creative expression can redirect counterproductive behavior enactments that put children at risk for additional emotional pain or punishment

THE IMPORTANCE OF RELATIONSHIP WITH CHILDREN WHO CLAM UP

While play, creative arts, and other sensory-based or action-oriented approaches can help children communicate their stories when words are too difficult, there is another key factor in the therapeutic

equation—relationship. The recent focus on interpersonal neurobiology (Siegel, 2012; see Kestly, Chapter 7, this volume, for more information) underscores its importance as well as explains why relationships heal; similarly, the significance of human interactions via the social engagement system (Porges, 2012; see Gray & Porges, Chapter 6, this volume, for more information) also supports the centrality of how therapists present themselves to their clients with respect to gesture, language and nonverbal, body-based communications. Despite any technique, intervention, or recommended practice, it is the relationship that not only supports children's capacities to self-express, but also is the core factor in all healing.

Relational healing occurs in many ways because each child and helping professional constitute a unique and dynamic relationship. However, it is most often demonstrated to young clients by the therapist's ability to be flexible, playful, and creative in responding to what children bring to treatment. For example, when children respond in their usual way to the therapist, the therapist responds in a different way from what the children have grown to expect. Therapists who are effective in helping children trust the therapeutic process also demonstrate a genuine interest in children's play, imagination and creative expressions. If the child promises to bring a poem she has written to the next session, the therapist remembers to ask her about the poem early in the next session. If a child shares an important dream in which a particular emotion is symbolized with great intensity, the therapist connects the symbolized affect to an experience shared by the child later in therapy when that same affect was powerfully experienced.

In brief, the therapist who uses play and creative interventions with children is able to convey what Winnicott (1973) reported that "good enough" mothers do or what art therapists have come to call "the third hand," a relational response that recapitulates the positive attachment found in early caregiver–child relationships (Malchiodi, 2015; see Malchiodi, Chapter 10, this volume, for more information). While we can tell children that we are here to support them and help them repair worries and hurts, it is most often our actions (nonverbal cues, sensory-based interactions and gestures) that communicate this support and positive social engagement. In countless past interactions, children who clam up have often come to expect rejection and negative judgments; in contrast, the therapist capitalizing on the "good-enough mother" and "third hand" responds with acceptance and authentic appreciation. The child expects judgment and criticism, the therapist responds with understanding; if an enraged child anticipates a punitive response, the therapist responds with tolerance. In the course of any play- or arts-based psychotherapy with children, the innumerable transactions between child and

therapist ultimately result in an emotionally corrective, relational healing experience rather than any prescribed method, activity, or technique.

CONCLUSION

The premise of this book is based on our belief that nonverbal, action-oriented approaches are key to helping children who cannot speak about the unspeakable or decline to talk about their experiences. In particular, the authors in this volume support the use of play and creative arts as ways to help young clients express what may not be communicated for the various reasons we have summarized in this chapter. Subsequent chapters in this first section detail the concept of resistance (Crenshaw) and how neurobiological factors (Gaskill and Perry) affect young clients' abilities to communicate in therapy. The second section offers a wide array of wisdom from expert practitioners in the fields of play therapy, psychology, social work, counseling, and creative arts therapy, supported by numerous case examples and advanced clinical experiences. In brief, these experts generously share their knowledge and diverse approaches to work with a variety of challenges, including trauma and loss, selective mutism, and disrupted attachment as well as typical situations in which therapists encounter youth who are reticent to talk about their feelings or "what happened." Most important, all chapter authors provide rich and detailed observations, applications, and recommended practices that demonstrate a variety of practical strategies that all helping professionals can use to help children and adolescents who clam up.

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