The Crucial Role of Empathy in Breaking the Silence of Traumatized Children in Play Therapy

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This article delineates the key role that empathy in the context of relational-based healing plays in enabling severely abused/traumatized children to break their silence to talk about horrific experiences that had rendered them voiceless. A case example involving an adolescent boy who had been severely traumatized is provided.

Keywords: empathy, traumatized children, abuse, violence, play therapy

Words can’t always tell the story when children are exposed to extreme violence, sexual abuse, and terror. Van der Kolk (2003) and Perry (2005) described the shut-down of the Broca area of the brain, the language center, in the face of terror. James (1994) explained that the phrase “mute with terror” has a neurobiological basis. When linguistic expression is not an option, play therapy with its embedded symbols, metaphors, and artistic images as expressed in drawings is uniquely suited for therapeutic communication with young children.

EMPATHY DEFINED

Clark (1980) defined empathy as “that unique capacity of the human being to feel the experiences, needs, aspirations, frustrations, sorrows, joys, anxieties, hurt, or hunger of others as if they were his or her own” (p. 190).
Clark elaborated further, “The inability of human beings with power to understand the legitimate needs and aspirations of other human beings—the inability of human beings to understand that their fellow human beings share their anxieties, their frailties, their posturing, their desire to make the most out of the limited interval of conscious and evaluative life—this lack of simple expanded empathy, in the eyes of this observer, is the basis of social tensions, conflicts, violence, terrorism, and war” (1980, p. 190).

Empathy, as defined by Epley, Savitsky, and Gilovich (2002), is a multidimensional concept (Feshbach, 1978), consisting of both cognitive and emotional components (Davis, 1983). It includes concern for others, sympathy (Cialdini, Brown, Lewis, Luce, & Neuberg, 1997), personal distress (Mikulincer et al., 2001), and perspective taking (Chartrand & Bargh, 1999). Empathy has been a key ingredient in effective therapies, ranging from humanistic therapists, like Rogers, to psychoanalysts like Kohut (Wang et al., 2003). Rogers (1980) defined empathy as: “the therapist’s sensitive ability and willingness to understand the client’s thoughts, feelings, and struggles from the client’s point of view” (p. 85). Rogers further elucidated the meaning of empathy by explaining that empathy requires entering the private perceptual world of another, being sensitive to felt meaning of the other even sensing meaning of which the other person is hardly aware.

EMPATHY AND PSYCHOTHERAPY OUTCOME RESEARCH

Barrett-Lennard’s (1981) operational definition of empathy included three different components and perspectives of empathy: (1) the therapist’s experience (“empathic resonance”), (2) the observer’s view (“expressed empathy”), and (3) the client’s experience (“received empathy”). Greenberg, Watson, Elliot, & Bohart, (2001) summarized the results of metaanalytic studies of empathy utilizing these three perspectives, and found that all three measures of empathy were significantly related to psychotherapy outcome.

THE EMOTIONALLY FOCUSED WORK OF THE EMPATHIC HEALER

What Empathic Healers Do

Miller (1983) explained that learning depends on listening, which then leads to even better listening and attentiveness to the other person. She
noted that to learn from a child, we must have empathy and that empathy grows in parallel with increased understanding. Pine (1987) elaborated on the transforming potential of empathy in therapy,

What an empathic statement . . . does is to provide a clarifying description of some inner state. I wish to emphasize . . . such statements can be mutative in themselves—potentially promoting a feeling of being understood, of self-acceptance, of greater affect tolerance in the region of what has been stated so that higher levels of function can be built around them (pp. 168–169).

Greenberg et al., (2001) pointed out that empathic therapists enable clients to symbolize feelings and experiences in words. The empathic therapist tracks their emotional responses facilitating the clients’ deeper reflection on their feelings, values, and aspirations. They noted that therapists need to pay as close attention to what is not said as to what is expressed.

Some Children Require In-Depth Emotionally Focused Therapy

The self and attachment problems associated with chronic childhood abuse and other forms of pervasive trauma must be understood and addressed in the context of the therapeutic relationship for healing to extend beyond resolution of targeted psychiatric symptoms and skill deficits (Pearlman & Courtois, 2005). There is no question that brief therapies can be effective in treating specific symptoms as manifested for example, in anxiety disorders. It is the thesis of this article, however, that those children and youth whose psychic wounds penetrate deeply to the core of their spirit, exposed to domestic and/or community violence, who have experienced repeated physical and/or sexual abuse, cannot be adequately treated in short-term therapy. The work required to heal the crushed spirit of a child, the children who populate the foster care system, particularly those placed in residential treatment centers, is intensive, in-depth, emotionally focused and based on empathic and relationship healing. The field of psychotherapy in general, and play therapy specifically has benefited enormously by the empirical studies that have focused on the nonspecific factors as well as specific treatment methods that have been tested and proven to be effective in psychotherapy outcome research. The children described in this paper, however, are not the children that are typically included in studies of empirically supported manualized treatments. They would usually be excluded because of the severity of their “disorders” and/or “comorbidity.”
Essential Ingredients in the Therapeutic Relationship

Establishing a relationship with severely traumatized children who are often filled with rage and sorrow, and sometimes violent, is a harrowing feat. It requires an empathic attunement that the children may not welcome because they have too frequently experienced betrayal, disillusionment, punitive measures, or attempts to control rather than genuine attempts to understand and to help them. It demands that children and youth, who have grown up in violent neighborhoods (Garbarino, 1999), who have been “incubated in terror” (Perry, 1997), experienced powerlessness, silencing, and voicelessness, to be empowered and assisted in reclaiming their voice (Hardy, 1998). It requires a profound respect for their humanity and dignity and an appreciation of the cultural, ethnic, economic, educational, social, neurobiological, and familial forces that have influenced who they have become.

FUNDAMENTAL TREATMENT PRINCIPLES

Empathy’s Role in Trauma-Informed Therapy

Gil (2006) summarized the current state of knowledge regarding treating sexually traumatized children. She states,

In addition to children’s natural resistance to talking about the abuse because of shame, guilt, fear, or lack of awareness that abuse is inappropriate, evidence also suggests that trauma memories are embedded in the right hemisphere of the brain. Thus, art, play, sand, and other expressive therapies may be necessary components of trauma treatment (Gil, 2006, p. 68)

In addition, work with highly at-risk youth reveals that it is through the trust developed in the therapeutic relationship that the child begins to risk closeness with another, it is through the healing experience of the therapist responding in an empathic manner that the child begins to develop empathy for self and others. Gil (1991) explained that abuse is interactional and typically occurs within the context of the family, thus the child can benefit from the opportunity to experience a safe, appropriate, and rewarding interaction with a trusted other person. Children, who have been exposed to extreme and/or chronic violence and other traumatizing events, can only through gradual confrontation with those events begin to develop with the assistance of the empathic healer a narrative memory of the trauma that eventually allows for putting those horrifying experiences in past memory and moving on with life (a process described by neuroscientists as moving
implicit memories into explicit or autobiographical memory [Siegel, 1999]).

It is through children telling their story, in the case of younger children through symbolic play, and having it understood and witnessed by someone trusted that they can begin to weave a new story, a new meaning and perspective on their lives. It is through the experience of being accepted even after sharing their most secret and shameful feelings and thoughts that these children come to accept themselves.

Today the vast majority of children referred to residential treatment centers have been exposed to violence that can take the form of witnessing domestic violence or being victims of physical and/or sexual abuse (Conner, Doerfler, Toscano, Volungis, & Steingard, 2004). Some children have experienced all of the above forms of violence, and not just once, but repeatedly. These are youth who have witnessed shootings in their neighborhood and children whose families are sometimes awakened by the sounds of gun fire in the middle of the night. Some of these children worry constantly about parents who suffer major psychiatric disorders, including schizophrenia or psychosis related to drug use or other organic causes. Many spent their early lives in economically deprived families and crime-filled neighborhoods, and were constantly surrounded by danger and threat. Many of their parents did the best they could but were overwhelmed with the oppressive forces of poverty, unemployment, lack of educational opportunities, and constant exposure to violence.

**Story Unfolds via Symbolic Play**

Play is the natural language for young children. Symbolic play in particular allows children to remain at a safe distance from trauma events and permits them to work at their own pace in approaching them. Gil (1991) elaborated, “The clinician always proceeds with caution, gingerly laying a foundation that advances a sense of security ['I have often imagined this step as the creating of a kind of sanctuary: quiet, accepting, stable, consistent, and free of external conflict']” (p. 54).

Children may spend many months engaging in play scenarios that resemble to an increasing degree the actual trauma events of their lives. Because the dramas are played out with play characters, such as a dog puppet, an alligator puppet or Army men and tanks, the children can maintain a protective distance until they are strong enough to confront directly the trauma events and unburden, to find their voices and tell their stories, about the heavy emotional load they have carried—in some cases secretly for many years.
Addressing Issues of Shame and Secrecy

Gil (1991) noted, “Privacy is very important for children; secrecy is not. Establishing privacy empowers; keeping secrets engenders feeling of helplessness” (p. 71). One crucial aspect of addressing the psychic wounds of children is to explore the ever so painful feelings of shame that almost always are rooted in forced silence and secrecy, the hallmarks of oppression of any kind. Children experience intense anguish when they disclose abuse; especially sexual abuse (Crenshaw & Mordock, 2004; Crenshaw, Rudy, Triemer, & Zingaro, 1986). The secrets carried by these children are so burdensome that they become a secondary source of potential traumatization. Gil (1991) observed,

Some abused children are threatened by their families or caretakers to keep all family interactions to themselves. They are told that they or loved ones will be harmed. Some of the children I’ve worked with have had demonstrations of what will happen to them if they tell others about secret family situations (p. 70).

Recognizing the Child’s Need to Unburden

One of the most valuable lessons we have learned directly from traumatized children, is that as much as they wish to avoid confronting the trauma events of their lives, there is an equally strong drive that emanates from the healthy part of the core self that longs to unburden about these events (Herman, 1992; Kestenberg, 1992). Whether it is helpful and therapeutic for a child to unburden will depend on many factors including timing, the child’s internal resources, strengths, and coping abilities, the degree of additional stress in the child’s external life at the time, the strength of the relationship with the therapist and the availability of support for the child outside of therapy (Droga, 1997; Gil, 1991; James, 1989).

Therapy Should Be Child Driven and Responsive

It is crucial to be guided by the child’s needs and not our own preconceived notions of what is good for the child or what “good therapy” should entail. It would be harmful to the child for the therapist to back away or discourage children from unburdening when they have finally reached the point of being able to talk or play out their terrifying experiences. In that case we would be leaving them alone to deal with these frightening inhabitants of their internal world.

The authors have worked with children and adolescents who in prior
therapy had given cues that they needed to talk about these things, but were not responded to. The child or adolescent felt, once again, abandoned. Some of these children carry on their backs, arms, or legs, scars, and/or burns. Therapists see their visible wounds, but unless they sensitively inquire about the child’s inner pain they may not see their invisible wounds. Visible wounds tend to elicit concern and empathy, but invisible wounds are apt to be unrecognized or even devalued though they often represent the most devastating injuries to the spirit of the child (Crenshaw & Garbarino, 2007; Crenshaw & Hardy, 2005; Hardy & Laszloffy, 2005). Conversely, if therapists push children into confronting the traumatic events before they are ready, there is the risk of retraumatization or flooding (Crenshaw, 2005; 2006a, 2007). In addition, the therapist may lose the trust and confidence of the child. These are sometimes difficult decisions, but there is a great deal of redundancy in the symbolic communications of children in both their play and their verbalizations, so if therapists are truly looking and listening they should not miss what children need us to see and hear.

A 9-year-old boy, Angelo, whose siblings were ravaged by sexual abuse in the night by his step-father who was in jail for these crimes to his sisters, over and over played out a drama in which a cat burglar would come in the night and steal the family jewels (Crenshaw & Mordock, 2005a). A theme stated frequently by the child was, “Everything of value has been taken.” This child felt deeply pained and burdened by his inability to protect his sisters. The siblings of abused children often suffer as much as those who are directly abused (Tyndall-Lind, Landreth, & Giordono, 2001). Angelo was plagued by persistent guilt and self-blame.

**Attending to the Deeper Wounds When Therapeutically Indicated**

Pynoos and Nader (1990) pointed out that children look to their parents to provide a protective shield. They raised the question of what happens if the parents are involved in breaking the protective shield. In that case, Pynoos and Nader observed that instead of isolated symptoms the impact is seen in the cumulative effect on the child’s personality development. They indicate that the wounds are deep and not easily healed; it leaves deep scars. Pynoos and Nader emphasized the restoration of trust and the need to really listen to the child to allow for unburdening. They noted that as adults we don’t really want to hear the horrors that can happen to children. The chaos and horror in Angelo’s life needs to be addressed before his going to a family, his own or a foster family. He has to address the painful issues that have caused lacerations to his soul.
Angelo needs to give voice to his story of horror and share it with someone he has learned to trust who can listen empathically so the invisible wounds can begin to heal.

It needs to be noted that not all children with similar life stories to Angelo’s will have adequate psychological resources to undertake the intensive and demanding emotional work of integrating their memories and associated powerful affects into a more coherent understanding and perspective. Guidelines have been developed to determine when a child is ready to proceed with trauma work, the invitational approach (a term suggested by James (1989), and conversely, when it is better to work on building defenses, identifying and highlighting strengths, and teaching problem solving and social skills (Crenshaw & Mordock, 2005a; 2005b). The latter approach has been called the coping approach (Crenshaw & Mordock, 2005a) and is primarily psychoeducational in focus. The life situations of some children are so horrifying that they simply can’t confront these experiences without the risk of retraumatization. For these children, a coping approach is indicated, at least, at this particular stage in their life.

**Developmentally, Culturally, and Child Sensitive Therapy**

The therapy above all needs to be child responsive and sensitive to what the child can handle at any given developmental stage (Shelby, 2000). James (1989) described the crucial importance of developmentally sequenced treatment with traumatized and severely abused children. Therapy also needs to be culturally sensitive and delivered by culturally competent therapists if the therapy is going to be truly child and family responsive (Gil & Drewes, 2004). Gil (2004) explained that short-term work with severely traumatized abused children will typically not address the complex treatment issues these children pose. Gil observed that our work is relationship based. Without a strong therapeutic relationship, all the possible creative techniques will not work. She further noted that each child requires something different so formulaic approaches to treatment obscure the need to get to know what this particular child in this specific time, place, and life circumstances and with his or her unique history needs to heal.

**BREAKING THE SILENCE: A CASE EXAMPLE—ROBERTO**

Roberto was 14 when he was brought to therapy by his adoptive parents at a time of crisis. Roberto has been suspended from school as a
result of groping a girl, age 11, on the school bus. Roberto was the only child living within the home of his adoptive parents, both professional educators. The parents had three biological children, two sons, ages 23 and 25, and a daughter, age 21. All were living outside the home and appeared to be making adaptive adjustments to young adult life. Roberto had three biological sisters, placed in three other adoptive families, ages 16, 12, and 10 at the time of treatment. He occasionally had visits with his sisters but not nearly as often as he wished.

Roberto and his sisters had been severely traumatized by repeated exposure to physical and sexual abuse and violence perpetrated by their father who was at the time in prison for his crimes. In addition to the physical and sexual trauma suffered by the children they lived in a daily milieu of terror. Roberto was at times forced to witness the sexual violations committed against his sisters and on some occasions, even the sexual abuse of his mother. Heavy drinking intensified his father's violence. The children were frequent witnesses to beatings of their mother usually precipitated by the mother's attempts to protect them from the father's rage and brutal assaults.

Like many violent men who batter their partners, Roberto's father kept the family isolated and under his tyrannical control. The children were not allowed to play with other children in the neighborhood or to invite other children to the house. When bruised or displaying a black eye, neither the mother nor affected child was allowed to leave the house. Consequently, this isolated "imprisoned family" escaped the detection of school authorities and child protective services until Roberto reached age 7.

The tragic culmination of the father's reign of terror came on a snowy Christmas Eve when the father, who worked as a mechanic, came home after hours of drinking with his buddies. Roberto's mother had cooked a ham for the special holiday meal, a favorite of the family. When the father didn't come home for dinner, the mother and the children enjoyed the dinner but were nervous about the father's absence. When the father came home he quickly became enraged in his intoxicated state that his wife had not cooked him a steak. The children fled in terror and huddled together in the bedroom that they all shared. They winced in pain at each scream and shouted obscenity, especially the chilling sounds of body blows. Eventually the shouts and screams ceased quite abruptly, followed by a disturbing silence, punctured only by the sound of the back door slamming.

The children, nearly frozen in fear, led by Roberto, ever so cautiously left their room and slowly, quietly, one tentative step at a time, approached the kitchen. They were deeply shaken by the eerie silence that pervaded the house. Roberto was the first, in horror, to fix his gaze, on the blood soaked floor and the still body of his mother laying face up with a kitchen
knife still stuck in her chest. His older sister run to the phone to call the police. Roberto was immobilized and frozen in space and time. His younger sisters ran back to the bedroom screaming and sobbing.

The children were placed together in an emergency foster home and then the two older children and the two younger children were placed in separate foster homes. Visits were arranged between the two groups of siblings every other week. Roberto was the last to be placed in a preadop- tive foster family at age 8 1/2. He was adopted by his family at age 9. He along with his siblings had participated in therapy provided by a mental health clinic and arranged by social services shortly after being placed in the emergency foster home. Roberto was rather vague about his prior therapy experience stating that he remembered playing some games with a nice lady whose name he could not remember. Reports received from the clinic indicated that at the time Roberto was too frightened to either play out or talk about the trauma events and that he was only interested in playing board games. After 6 months the clinic therapist recommended discontinuance of therapy because of the lack of clear benefit.

Until the incident on the school bus Roberto had exhibited only a few signs of serious maladjustment, although he did struggle in school with his academic work and socially he was viewed as a loner. He also suffered nightmares and sleep difficulties on a regular basis. At the time of the crisis visit, we discussed in a family session the sexually aggressive behavior on the school bus. Roberto seemed to understand the seriousness of the behavior and he was able to show some concern for the young girl but he had no explanation for his behavior nor was there any attempt made in the initial sessions to connect this incident to his own sexual traumatization. It was clear from the extent of the horror of Roberto’s nightmarish early life that approaching this probable link would need to be done carefully and with judicious timing to reduce the risk of retraumatization.

The early focus in keeping with the coping track was on building the therapeutic alliance. Close attention was paid to strengths he exhibited such as his wish to be helpful to others, his kindness toward animals, his caring and concern for his sisters, and his knowledge of country music. We worked on coping strategies to manage anxiety and to control impulses. He was motivated to control his sexual impulses especially since he did not want to ever get into such serious trouble again. More importantly he felt sincere remorse for the hurt he caused the younger child. He created with the encouragement of his therapist a “Coping Toolbox” that contained such tools as deep breathing and muscle relaxation exercises, distraction techniques, mood management skills, reminders of resources within as well as the support contained in his family system. He drew pictures of members of “His Team” (Crenshaw, 2006b) to create visual reminders of people in his home and school environment that were there to help and support him.
He also drew concrete visual reminders of some of the reality consequences that he might face if he were to repeat his sexual transgression including expulsion from school, perhaps placement in a youth correctional facility, or perhaps even jail depending on his age at the time. In contrast to these grim reminders of the punitive consequences he could face, he was urged to draw pictures of the future he would like for himself. Interestingly, he drew numerous pictures of himself and his dog living alone in a secluded area with lots of trees, flowers, and a large yard. Roberto was not ready to include another person in his vision of the future.

As a result of empathic listening, strengthening of his coping resources, and validation of his many redeeming qualities and traits, Roberto was ready after about 6 months to begin the scary process of confronting the past. His past haunted him in the form of sleepless nights, terrifying dreams, and disturbing intrusive images that had interfered with his ability to attend and focus in school and contributed greatly to his erratic academic performance.

The way in which Roberto began his harrowing journey was totally unexpected and unprecedented in our clinical experience. Roberto got down on the floor and at age 14 1/2 pulled the toy family house off the shelf. The therapist joined him on the floor and for nearly a year Roberto and his therapist never returned to sit in the chairs in the office. During that period he enacted violent and horrifying scenes in which family members, the mother and children in the play family were terrorized and sexually assaulted by a disturbed, out-of-control, frequently drunken, and violent, sadistic man.

Some scenes were repeated often and when they assumed characteristics of posttraumatic play (Terr, 1990) and particularly when he appeared to be “stuck” in unproductive repetitions of trauma events the therapist intervened in the manner prescribed by Gil (1991, 2006). The therapist would, for example, call on rescue heroes to enter and take command to halt the violence. The rescue heroes often symbolically represent resources in the child’s interpersonal world, adults that the child can potentially turn to for help and support. In addition, although remaining in the metaphor healthy resources displayed by the family members in the play family in the face of terror were delineated, including acts of courage, caring for one another, attempts to protect others and perseverance under the most extreme circumstances. It should be noted that consistent with Gil (2006) we recommend in the case of severely traumatized children remaining in the metaphor until they give some indication of being ready to talk directly about the trauma events.

Although it is unusual for 15-year-old teens to engage in symbolic play with a toy family house, this child had been “incubated in terror” (Perry, 1997). He was processing the trauma events in the experiential mode.
consistent with the cognitive and emotional capacities typical of children six and under. This coincides with the time in his life when these horrific events occurred. Roberto had never spoken of his mother’s shocking and brutal murder or the frightening events leading up to her tragic death. Just as Roberto was frozen in a moment of unspeakable fright upon viewing his mother’s body, a portion of his emotional life has been immobilized and severely stunted since that horrible time.

Roberto would never have played out the stories that words could not tell if sufficient trust, security, and safety had not been established in the therapeutic relationship. Empathic listening, empathic responsiveness in the form of attunement to nonverbal communications, emotional and bodily states, as well as empathic interpretations (Crenshaw & Mordock, 2005a, 2005b) play a vital role in facilitating the secure therapeutic attachment. The neuroscience research has demonstrated that the establishment of a secure attachment within the therapeutic setting enables a person to face emotional states that would otherwise be intolerable and work them through in such a way that they can be more safely managed, transformed, and eventually stored in explicit memory (Schore, 2003a, 2003b; Siegel, 1999, 2007).

After Roberto had used the language of symbol, play, metaphor, and image to create a coherent narrative of his horrific and terrifying experiences during the first years of his life culminating in his mother’s murder, his nightmares and the haunting intrusive images significantly subsided and over the next 6 months became less and less frequent. He also began to improve in his academic work because for the first time he was able to consistently focus his attention and energy on learning. In his therapy sessions he no longer sat on the floor nor did he engage in symbolic play. His focus in the sessions became more age appropriate as he shared concerns about girls, sports, friends, and issues of identity, including issues around his emerging sexuality.

An additional crisis occurred about 7 months after this turning point in the therapy. Roberto was ordered along with his siblings by a family court judge to have a supervised visit with his father on his imminent release from prison. This development was unexpected and because of the enormous fear and anxiety it triggered in Roberto appeals were made to the judge to delay the visit that was granted. The request, however, to cancel the visit until a later time when Roberto and his siblings could be better prepared for the visit was denied. During this period of 3 months proceeding and for 2 months after the mandated visit, Roberto at this point, 16-years-old, once again returned to the floor with the therapist joining him where he once again enacted some of the terror-filled moments of the past. Trauma severely disrupts memory systems, and the goal of integrating memory fragments (implicit memories) into a coherent narrative that can
be stored in explicit memory is a crucial goal of trauma therapy (Schore, 2003a, 2003b; Siegel, 1999, 2007). Another essential goal of therapy with severely traumatized children is to facilitate the shift from behavioral enactments into symbolic reenactments where the trauma events can be safely worked through. By contrast, behavioral enactments expose children and sometimes others to risk and possible harm. An example is the sexualized behavior toward the young girl on the school bus. At the time of the incident, Roberto had no conscious link between his own sexual trauma and his behavior on the bus. After he began to enact through play and symbol the trauma events, however, there were no further incidents of such behavioral enactments.

Remaining in the metaphor of the play family the therapist placed emphasis in Roberto’s symbolic enactments on how the kids in the family are older now and have more choices and means of keeping safe. Roberto, who had resisted this intervention in the past, readily adopted this empowering stance. He evolved a plan in which all of the children would carry a “walkie talkie” and at the first sign of the father losing control, the first one to notice would call the police. In addition he invited a character named “Uncle Bill” (representing the mother’s brother—William) to move into the family playhouse to make the kids safer. Roberto, who had resisted this intervention in the past, readily adopted this empowering stance. He evolved a plan in which all of the children would carry a “walkie talkie” and at the first sign of the father losing control, the first one to notice would call the police. In addition he invited a character named “Uncle Bill” (representing the mother’s brother—William) to move into the family playhouse to make the kids safer. In addition he invited a character named “Uncle Bill” (representing the mother’s brother—William) to move into the family playhouse to make the kids safer. The day that the therapist met with Roberto just 2 hours before his court ordered meeting with his father will be etched in the therapist’s memory forever. Roberto was so scared that initially he was trembling. The therapist was directive in this session and asked him to huddle up the children in the play family to talk over and play out the different ways to keep themselves safe. By the time Roberto was ready to leave, both therapist and Roberto still on the floor, they were able to talk directly about coping strategies for managing his anxiety about meeting his father for the first time since his father killed his mother.

Roberto’s fear was partly in reaction to being in the company of his father even though he was quite aware that there would be a court appointed supervisor present at all times and a security guard nearby to ensure the safety of Roberto and his sisters. A major source of his anxiety, however, was the fear of his own rage at his father. In rehearsing the visit in his mind, he pictured himself screaming at his father, “You bastard, you killed my mother!” Upon sharing this fantasy, Roberto began to sob in a heartfelt manner. The loss of his mother, who he deeply loved and who did her best to protect Roberto and his sisters far exceeded the pain of any other violence suffered at the hands of his father. When he got up to leave the session, for the first time, he turned to the therapist and spontaneously embraced him in a “bear hug” that communicated in a way that words fail, the heart to heart connection they shared at that unforgettable, poignant moment.
POSTSCRIPT

Roberto is now an adult. He lives in a small city in the region where his former therapist still practices. He is married and has a 2-year-old son. He still calls the therapist from time to time and after his son was born he stopped by with his wife to proudly introduce his new son.

Children will not share their stories, even through the symbolic haven and safe distance of play unless they are convinced that an empathic healer is present (Gil, 2006). If the child does not have a trusting relationship with an adult perceived to be caring and capable of responding to their pain in an empathic way they will not feel safe and little that is therapeutic will happen. This process cannot be rushed, pressured, or forced. It has to evolve in a natural way as a result of gradually coming to view the healer as fully committed to their well being, competent, and caring enough to see them through the arduous journey of facing and learning to live with the horror and trauma of their early lives. The authors can’t help but wonder how many voiceless children there are, whose stories remain untold because there is no empathic healer present?

How privileged we are as play, child, and family therapists to be facilitators of the stories that children need to tell, of the secrets that need to be shared, of the unburdening of loads too heavy to carry and to witness the pain that had previously been borne alone by a lonely and weary child. It is through the healing power of empathy and trust that children gradually tell the stories that need to be told in whatever language they can share them (verbal, artistic images, symbols, pictures in the sand tray, or enactments in symbolic play). Is there a greater privilege? We don’t believe so. It takes courage, a lot of courage for both child and therapist. It is the work of empathic healing. It is the work of helping children to break their silence.

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