AN EXPLORATION OF ADULT PATIENTS WITH HISTORIES OF CHILDHOOD TRAUMA: THE ROLE OF PLAY IN THE TREATMENT

by

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A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

AN EXPLORATION OF ADULT PATIENTS WITH HISTORIES OF CHILDHOOD TRAUMA: THE ROLE OF PLAY IN THE TREATMENT

by

Whitney B. Ross

Advisor: Professor Jeffrey Rosen

In this paper I have focused primarily on the impact that early childhood trauma can have on one's development and on one's capacity to play and to be a playful adult. I have combined my personal experiences, both as a clinician and as a survivor of early childhood trauma, with a body of literature complemented with interactive data obtained from senior clinicians. The data will hopefully be used to achieve greater insight, and to develop useful tools for working well with this patient population.

Acknowledgements

Dr. Jeffrey Rosen was a mentor to me before he realized it. His calm, steady approach to navigating the chaos that often comes with graduate work was evident during my first days as a doctoral student more than nine years ago. I was flattered and grateful when he agreed to include me in a dissertation study group and, later, to chair my thesis. For enduring my anxiety, distraction, and drama and for being a calm, steady, steadfast mentor and friend, I thank him. My gratitude is enormous.

I asked Larry Gould and Steven Tuber to participate on my committee because of relevant expertise and because of my long-standing and now close connection to each of them. Steve chaired an earlier paper and I have worked closely with Larry in myriad capacities. I have tremendous respect for both of them. They were instrumental in providing unwavering support and thoughtful guidance throughout the dissertation process.

Diana Diamond interviewed me for the Ph.D. program at City University nine years ago. I had given birth to my son less than a week before meeting her and I was somewhat overwhelmed by my new life. Diana, with her thoughtful and inquisitive probing of my intention to pursue doctoral work, pushed my thinking from early on. Her participation as a reader on my committee was very valuable and I appreciated her time and insightful comments.

Many friends have been profoundly helpful along this journey that has included my dissertation. It's impossible to describe how important seemingly benign comments like, "I'm so impressed with your work," and, "you're so dedicated," etc. have been.

Lucille Buck, Holly Cunningham, Ellen Eagen, Jen Edstrom, Wendy Flynn, Lisa Frelinghuysen, Janell Hobart, Evelyn Lasry, Hannah McCouch, Phoebe Outerbridge, Devon Morehead, Denise Scully and Julie Son, I thank you. Laura Bilicic, Amy Harris, Leslie Johnson and Nicole Vidor fall into the category of friends who not only said the above, but also said things like, “ok, would you just finish already?” They have spent countless hours caring for my children and even more hours encouraging me when I fantasized about dropping everything to work in a pet shop.

I developed my interest in the field of psychology many years before starting graduate work. Sharon Powell and the late Janet Stoltzfus encouraged and nurtured my early interest. Supervisors have been instrumental, but two stand out in particular: Elena Lister and Steven Elig. Elena began supervising my work in 1990 and quickly became a trusted mentor. Today she continues to be an invaluable mentor but is also a colleague and dear friend. And without Steve Elig this document would still be sitting, half completed, on my desk. Supervisor, mentor, cheerleader, drill sergeant, and friend, Steve was the mentor-with-a-mission I needed. I want him to know that part of the reason I finished this paper is that I could no longer bear his stunned laughter in response to my procrastination. There will always be good scotch (and Veuve Cliquot for Julie) waiting for him in NYC.

My mother-in-law-and father-in-law, Caroline and Roger Moseley, sparked in me a love for learning at their kitchen table twenty-five-years ago. They have been tremendous supporters of me and of my work for many years. I am grateful for their belief in me. And I want to thank my parents, Sarah and Ted Whitehouse and Dennis

Ross, and my siblings, Hillary Hayes and Dennis Ross, for being proud of me and of my accomplishments.

My son, Ross Moseley, was seven months old when I began my doctoral work and my daughter, Parker Moseley, was born the year I finished my class work four years later. Ross, who when he was four thought I was studying to be a paleontologist (and was disappointed when he later learned that I wasn't studying dinosaurs after all), he is now very proud of me and of my accomplishments as a psychologist. I did a better job explaining what I do to my second child. Parker, age four, knows that I "help people with their feelings."

While my commitment to Ross and Parker has at times interfered with my work, and vice versa, my love for them is limitless. They make me smile and laugh and warm my heart. I wish for them the opportunity to study in depth something they love, as have I.

And last, Stephen Moseley, my husband of fifteen years and friend for twenty-five has been my greatest supporter. I want to thank him for his unwavering support that spans so many years and so many areas of my life. He encouraged me to pursue my desire to accomplish the goal of earning my Ph.D. and with financial, emotional, technical and proofreading support, helped to make it possible.

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Introduction

> "We commonly do not remember that it is, after all, always the first person that is speaking. I should not talk so much about myself if there were anybody else whom I knew as well."
> (H.D.Thoreau, Walden)

Cautiously, and in the spirit captured by Thoreau, I have endeavored to explore through the course of this dissertation some of my experiences as a child who grew up in a chaotic and often violent household. I have used my experiences (both as a victim of trauma and as a clinician) to inform and explore an understanding of theorists (several of whom are victims of trauma) and also the experiences of patients (as conveyed by their therapists) who have experienced various forms of trauma.

In this paper I have focused primarily on the impact early childhood trauma can have on a patient's development and on one's capacity to play and to be a playful adult. It has been my goal to combine my personal experiences and reflections with a body of literature and with discussions with clinicians in order to achieve greater insight and to develop useful tools for working well with this population.

Dr. Susan Brison, a professor of philosophy at Dartmouth College, a scholar, a writer, and a victim of a brutal rape, wrote Aftermath, a memoir that has profoundly affected my recent thoughts and feelings about trauma and how to examine and describe it. In Aftermath, Brison writes clearly and eloquently, and with a controlled focus that is admirable. She tells her story while weaving in trauma theory, clinical implications of trauma and treatment options. Brison argues several times in her memoir (in fact it may be her overarching theme) that important topics such as one's experiences of trauma and

abuse must be talked about by those who have experienced the trauma – in their own words.

In the first pages of her book, perhaps as a disclaimer or perhaps because she is a woman and an academic working in a competitive, tenure-track world, she appears to feel the need to justify the contents of her powerful and very personal book.

> Some may consider such a first person account in academic writing to be self-indulgent, but I consider it a welcome antidote to scholarship that, in the guise of universality, tends to silence those who most need to be heard.
> Aftermath, p. 6

And even if the writing is self-indulgent, which this piece certainly is in some ways, I do not believe that it makes the work less important or less credible. In fact, I could argue that it is just the opposite. Who better to study something than someone for whom the issue or topic is of paramount interest or importance? Who better to learn from than someone who has experienced that which she studies and describes? But there is a caveat of course: that the research is fair and balanced and that blind spots and prejudices are explored and examined, too.

I have attempted to do a lot with this research: to explore and research topics that interest me in ways that are both interesting and scholarly. I have also tried hard to be fair and balanced and to look at suggestions and criticism with determined focus. Two trusted clinicians told me that they thought the research was slanted in a way that was too personal and that some of the personal anecdotes detracted from the credibility of the research. I have read this document many times and have attempted to edit it thoughtfully. I appreciated the important critique and believe it has led to a tighter, more relevant piece of work. But I am also sure that there is a lot of me in the work. I have

shared many personal stories, feelings, beliefs and anecdotes – those which I hope add to the understanding of and connection to the topic. Writing about and in many ways working through some of my own experiences with trauma has no doubt been cathartic but I also hope that the personal nature of the work helps readers both believe it and connect with it.

While I was once embarrassed and even horrified and disgusted as a result of my experiences as a child and adolescent, I no longer am. I can talk about my experiences, think about them and about the negative consequences and sequelae as well as about the many positive consequences that have come as a result of my history. And I hope I can be helpful to people as a result of my understanding. I have learned to be playful about my experiences – I can banter and joke about them albeit often with a masochistic twist. I have come to believe that humor is an important component when talking about trauma. Without it trauma can be so grave, so dry, and so scary, it's difficult to read about or talk about. And I want people to think about and learn about different ways in which trauma affects people's lives and what we can do to recognize it and help people manage the consequences of it.

Some Personal History with Trauma

Nearly four years ago I moved to Southern California with my husband, our then four and a half-year-old son, ten week-old daughter, two dogs and our babysitter of four and a half years. Uprooting our family from New York City was a significant task complicated by my long-standing and intense aversion to change, a generalized anxiety disorder and my newly postpartum body. My husband's job was the reason for the move

and while I put on a brave front (most of the time) and valiantly played the role of supportive wife (most of the time) I was also anxious and angry (largely unconsciously) and clung madly to anything familiar. I was not in a playful or adventurous mood or state of mind.

Indeed, playfulness is not my natural state. I order the same dishes in the same familiar restaurants. I shop in the same stores and own too many pieces of black, brown and navy clothing. I drive the same streets (despite traffic patterns) in New York City and politely (usually) suggest taxi drivers follow my routes. And until fairly recently I couldn't leave my home without all the beds made, toys and extraneous objects put away and pillows fluffed…and creased; and I still don't *like* to. Many of my habits and patterns are obsessively repeated.

One afternoon three years ago, I was sitting at a table at the Atheneum – the music and arts library in downtown La Jolla, California, obsessively organizing and straightening my papers in preparation for settling down for an afternoon of work on my dissertation. With Bach's Brandenburg Concerto #5 playing softly I suddenly had the urge to fling my papers and books everywhere in a dramatic display of …I wasn't sure if it was anger or playfulness. I have come to realize that it was both.

I have since thought about that moment on many occasions. Was I feeling overwhelmed by the mounds of books and papers, some of which I had read and many of which I hadn't, or was I feeling overwhelmed by the dissertation process in general? What was the significance of flinging everything everywhere? What was it about the wish to throw a tantrum or to create a chaotic mess in a playful way? Was it compelled by my wish to throw my dissertation literally and figuratively out the window, or to poke

fun at the drama of the exercise? And the Brandenburg Concerto – the same piece that was playing when I walked down the aisle to marry my husband eleven years earlier…was my fantasy a response to the realization that with the move to California my life had been turned upside down and I was twisting with anxiety and uncertainty and chaos and I was feeling angry with my husband (*perhaps* unfairly) for my plight?

While thinking that afternoon about the entwined feelings of anger and playfulness, I remembered a comment a therapist had made to me a couple of years earlier but had forgotten until that moment. In response to an interpretation he had, I expressed resistance. His response to my resistance was to recommend that I "just play with it…" ostensibly until the next session. My initial reaction was (because I wanted to be a good patient, to do what I was told and, more importantly, to "get" what he asked me to do and do it the "right" way) that I nodded and thought to myself, "sure…I can do that, I can 'play' with it." The session ended, and by the time I walked out of his office I had forgotten what it was I was supposed to "play" with. But I do remember feeling enraged and overwhelmed – a feeling I have since come to recognize and identify as "flooding." My reaction leaving his office was, with almost a smirk, "I'm not going to *play* with it…I'm an adult, I don't *play*." And I promptly forgot the exchange until a couple of years later. I now realize that I needed to compartmentalize this feeling of being overwhelmed or flooded in order to continue with my day and my life. Warding off these overwhelming feelings was a powerful and adaptive defense.

When I think about and talk about my experiences of warding off overwhelming feelings being "powerful" and being "adaptive," I often muse about the following: what is adaptive about it? When and under what circumstances would others choose the same

defensive strategy? What would it be like to sit with the powerful feelings? When one becomes more rigid, less playful and shuts down a part of her thinking, what might she be defending against and at what cost?

The juxtaposition of anger and playfulness is of interest to me and is certainly an important part of my own character structure. I grew up in a household plagued by habitual violence and I experienced a lot of early childhood trauma. The police frequented our homes, we moved a lot, and life was unpredictable. My (first) stepfather's moods were unstable and very unpredictable.

This stepfather died in prison in South-Central Los Angeles several years ago, and it was from his death certificate and from prison records that I learned he had suffered from bipolar disorder and obsessive-compulsive disorder for most of his life. It explained a lot of the drama, and a lot about his manic rages, and the violence and the unpredictability with which we lived for so long.

I grew up in a household where vigilance was critical. I learned to be aware of people's affect, moods and body language, and to gauge my surroundings carefully and fully. I can certainly imagine a child responding differently and know children who have responded to trauma in different ways. I was the watchful one. Today I often think about the following: if I hadn't watched, who would have? Could I have been spared this burden? What did I gain from my role? And what is it like to be oblivious and to have defenses powerful enough to shut out the chaos? What kind of toll might that take? Or does it insulate one enough to allow continued life progress and miss being plagued and influenced by what could have been seen?

As a child and later as an adolescent I keenly remember watching and waiting, with my shoulders and neck tensed, to see if a particular comment I made casually and then regretted (like, “what are we going to do today?”) would shift my stepfather’s mood into a calm, playful place or would send him into a rage. I was acutely aware of the tone of my voice and of my body language and was focused on my stepfather’s body language at the same time. If his body language or eye contact suggested to me that he seemed calm, I would carefully continue to engage him. If, however, at any point in the conversation I sensed him twitch or tense up, I still had time to shift my focus – to ask the question or make the suggestion a different way – or back off. It was a game – an exhausting one with high stakes at times. But it made me feel powerful to play. I realize now that I felt special - special and powerful for recognizing his mood shifts, for being able to ride his manic wave, shifting my balance, bending forward or back to regain balance. It wasn’t easy, and I often got banged up, but when I succeeded it was gratifying – exhausting, maybe, but I felt successful. I had figured him out and avoided a major blow-up or been able to survive hours of screaming, violence and drama without physical damage.

When children are exposed to habitual violence they need to adopt protective mechanisms. Dr. Judith Herman, in Trauma and Recovery argues that, “children in an abusive environment develop an extraordinary ability to scan for warning signs of attack. They become minutely attuned to their abuser’s inner states. They learn to recognize subtle changes in facial expressions, voice and body language as signals of anger, sexual arousal, intoxication or dissociation.” (p. 99) And this can be exhilarating.

Many of the psychoanalysts interviewed in this study talked about their patient's feelings of "specialness." Critical questions explored later in this paper include: where does this sense of "specialness" come from? How can one who is victimized truly feel "special?" How does the specialness manifest and what are the benefits and consequences of taking on this role and experiencing life in this way?

When my stepfather was beyond the possibility of being pulled into a playful space, nothing I said or did could calm or humor him. Back-peddling irritated him and apologies made him angrier. It was best to be silent and to let him determine the next move. Then my life and the lives of my mother and siblings would be scary and unpredictable – full of screaming and crying, threats, and verbal and physical violence, sometimes for many hours. And in this way I learned to swim in a dangerous current. My skills had failed me, or, perhaps, nothing I could have done would have worked.

"Trauma often creates considerable distrust, doubt, distortion and confusion in the patient." (H. Blum; Psychoanaly. Quart., 56: 609-627) I would add "anger and longing": anger about many things (in my case for not being able to go to sleep without the fear of being woken up by screaming, or banging, breaking dishes, etc. for not being able to bring friends home without the fear that they would witness a violent scene, for not knowing if we would be asked to leave the grocery store or a restaurant and for not having a "normal" life), and longing for freedom to experience the world without these fears.

The focus of the work for this paper has been to explore with practicing psychoanalysts their experiences working with psychotherapy and psychoanalytic patients who experienced trauma in childhood. I am specifically interested in adult

patients who grew up in families in which there was violent behavior identified by the patient as "extreme and/or habitual." I am interested in the patient's subjective understanding of his or her experiences as understood and perceived by the analyst.

I have interviewed psychoanalysts about their patient's subjective experiences as well as the analysts about their *own* experiences working with these patients. With the aid of a semi-structured interview, the analysts and I have together thought about the connections between patient's early lives and the impact on a patient's capacity to be "playful" as an adult. It was through the course of the interview process that I attempted to flesh out and to explore what playfulness and the ability to play as an adult means for this specific patient population.

Exploring thoughts about the patient's early connections, relationships and the importance of mentors was of particular interest. Winnicott wrote, "It is the surroundings that make it possible for each child to grow, and without adequate environmental reliability the personal growth of a child cannot take place, or such growth must be distorted." (The Family and Ind. Dev.; p.31)

So what happens when a child's surroundings are *not* reliable and are in fact, often dangerously unpredictable? Winnicott believed that it is a parent's job, in order for a child to feel secure and to ensure healthy development, to keep that child "safe from the unexpected, from innumerable unwelcome intrusions, and from a world that is not yet known or understood." (ibid; p. 31) What is life like for the child (and later, the adult) who grows up without what Winnicott might call a right, and others might call a luxury? A series of key questions include: what happens to the child who, when she plays, knows that the happy, carefree moments can instantly be transformed into something scary and

perhaps dangerous? Is play (and life in general) scarred by fear and anxiety – or at least caution and watchfulness? What does this patient look like later in life? The following exploration attempts to think about and unpack some of these questions.

Contents

Part I is my introduction where I have outlined and described the study as well as shared several personal and professional vignettes and questions relevant to this topic.

Part II is the contents.

Part III is a review of the literature on trauma and play.

Part IV summarizes the literature review.

Part V begins with a description of the focus of the study followed by part VI and a discussion of the methodology.

Part VII is the results section of the document.

Part VIII is the discussion and Part IX is the summary and implication for treatment.

Review of the Literature

I have reviewed in this section, literature on trauma and literature on play. I begin with definitions of trauma and trauma theory espoused by several prominent theorists including two theorists who have particularly influenced my work, Dr. Judith Herman and Dr. Lenore Terr. In addition to the research by Drs. Herman and Terr, the works of three women writers (Ms. Janette Walls, Dr. Annie Rogers, and Dr. Susan Brison), each of whom are victims of trauma, profoundly influenced my work. Janette Walls is a survivor or profound neglect and years of exposure to extreme and habitual fear and violence, Dr. Rogers is a survivor of profound sexual abuse and torture and Dr. Brison was left for dead after being brutally raped. By combining the writings and works of several additional theorists with the writings and experiences of these five women (infused with descriptions and thoughts from my personal and professional experience with trauma) I have attempted to create a thoughtful picture of what trauma might look like and mean to trauma patients and to the clinicians who work with them.

In the second half of the literature review I have highlighted various definitions of play from the adult literature and thoughts about ways in which adults “play.” I have then attempted to combine thoughts and questions about how the two (trauma and play) overlap.

Trauma

For the traumatized, the future is a landscape filled

with crags, pits and monsters.

L Terr

Defining Trauma

The American Psychoanalytic Association's, Psychoanalytic Terms and Concepts, defines trauma as "The disruption or breakdown that occurs when the psychic apparatus is suddenly presented with stimuli, either from within or from without, that are too powerful to be dealt with or assimilated in the usual way." (p.199) Essentially the ego is overwhelmed and unable to function in its usual capacity. Moore and Fine go on to explain that people respond in individual ways and that there is a vast continuum when talking about trauma. They argue that in terms of profound trauma people respond in a variety of ways, from having negligible consequences to consequences that are completely debilitating. It is the "intensity of the stimulus in relation to the preparedness of the stimulus barrier (or the ego) that is critical, but in terms of less severe trauma or intra-psychic conflict, constitution and past experience determines how well the ego will deal with the trauma." (p.199)

Judith Herman, an M.D. and clinical professor of psychiatry at Harvard medical school and the Director of Training at the Victims of Violence Program in the Department of Psychiatry at Cambridge Hospital in Cambridge, MA, is the author of Trauma and Recovery and Father Daughter Incest. Herman describes trauma or traumatic

events as "those that instill a feeling of terror and helplessness." (Herman interview, 1991)

An interesting distinction Herman makes is between fear and terror. Fear, she argues, is something that humans, along with all animals, are biologically programmed to feel and experience when we are in danger. "When we perceive danger, we alert, we startle, we look around and figure out, do a quick appraisal of the situation and we either fight or flee." (ibid.) "Fight or flight" doesn't work, however, she argues, in conditions of terror and helplessness – her definition of trauma. This strategy doesn't work because the ego is overwhelmed and can't respond with either action.

Another expert on trauma, Lenore Terr, M.D., is a clinical professor of psychiatry at the Langley Porter Psychiatric Institute at the University of California, San Francisco. Dr. Terr wrote Too Scared to Cry, Unchained Memories and Beyond Love and Work: Why Adults Need to Play. Her work is based on studies including the Chowchilla kidnapping study, a retrospective study of twenty school-aged children with varied trauma histories that were documented by third parties, and a study of typically-developing latency-aged children's and adolescents' responses to the Challenger space shuttle explosion. In addition, her work is based on clinical material working with more than 150 individual children presented for evaluation or treatment after myriad traumas. (Terr, 1991)

Terr describes childhood trauma as "the mental result of one sudden, external blow (she calls this type I trauma) or a series of blows (type II trauma) rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations." (Terr, 1991; p.11)

Both Terr and Herman allow for both one single event and the result of cumulative, on-going events to constitute trauma. They each focus on a sense of helplessness. Herman uses the term “terror” when defining trauma and Terr describes how the event renders a person unable to access “ordinary coping and defensive operations.” Both are relevant and together provide a richer definition of trauma. The terror may be what gets in the way of one being able to access coping and defensive strategies. And it is a result of the absence of these strategies that may lead to the symptoms and consequences described by Terr: hyper-arousal, re-experiencing and numbing.

Consequences of Trauma

> The survivor (of trauma) is left with fundamental problems in basic trust, autonomy and initiative. She approaches the tasks of early adulthood – establishing independence and intimacy – burdened by major impairments in self-care, in cognition and memory, in identity, and in the capacity to form stable relationships. (Herman)

Terr analogizes psychic trauma to devastating diseases like rheumatic fever which can cause prolonged and permanent developmental problems in children. Psychic trauma, Terr argues, can lead to “a number of mental changes that eventually account for some adult character problems: certain kinds of psychotic thinking, considerable violence, dissociation, extremes of passivity, self mutilative episodes and a variety of anxiety disturbances.” (ibid, p.11) Terr also describes characteristics associated with childhood trauma – “thought suppression, sleep problems, exaggerated startle responses, developmental regressions, fears of the mundane, deliberate avoidances, panic, irritability, and hypervigilance.” (ibid, p.12) Repetitive behaviors are also seen through play and reenactments of the traumatic event(s).

“Trauma-specific fears,” Terr argues, are fears similar or related to the trauma. She explains, for example, that “neurotically or developmentally phobic children may fear all dogs but the dog-bitten youngster will fear the German Shepherd or whatever species actually bit her. Another example is that neurotically anxious children might fear growing up, getting married, etc. while traumatized children fear oral sex, anal sex, etc. and can imitate through play and reenactment, the specific events. (Terr, 1991)

Terr describes how individuals traumatized as children can display “changed attitudes about people, life and the future.” These individuals might have a sense of a “severely limited future” or might say things like, “I live one day at a time,” or “I can’t

guess what will happen in my lifetime." (ibid, p.13) They might also indicate problems with trust manifested as a lack of trust or belief in the police or authorities and a sense that no one can be counted on for protection or help. (ibid., p 13)

When I consider consequences of trauma my first association is always, "head trauma." The association, is, I think, a result of the way I have repeatedly seen people react to, hear about, or experience trauma. Trauma connotes that which is serious, harsh, dramatic and inescapable. Trauma stays in your head, in your body and with you, forever.

> at the time I did not yet know how trauma not only haunts
> the conscious and unconscious mind, but also remains in the
> body, in each of the senses, ready to resurface whenever
> something triggers a reliving of the traumatic event.
>
> preface, Aftermath

Experiencing trauma directly clearly has consequences and will be discussed in a variety of ways through the course of this paper. Another form of trauma discussed far less frequently (absent from the literature found and the clinical interviews conducted for this study) is that which is experienced as a result of someone *else's* experiences. It is worth mentioning here, because the reactions evoked may be similar to and consistent with reactions evoked by trauma that is experienced directly.

Many years ago a close friend and colleague lost her six-year-old daughter to leukemia. I sat with her for weeks and months, listening to her talk about her child's pain, fear, stress levels, and trauma as well as her own as a mother. I tried hard to empathize with Elena (my friend and colleague) and I certainly thought about Liza (the sick child) and the family often, but it wasn't until I visited Liza in the hospital, in isolation, hairless as a result of chemotherapy, and drastically swollen with steroids, that I began to absorb the impact of the trauma that was affecting this child and her family. I will never forget

the image of Liza, age five, staring back at me, through the glass, curious about the gift I brought her which had to be sterilized before she could touch it, and with a look that I thought suggested a longing to be free – from the hospital as well as her disease. I remember feeling so afraid – that she would die, or that she wouldn't and would remain in that state forever. I think I was also afraid that one day I could have a child who would suffer like Liza was suffering and that I would suffer pain and fear that I could only begin to imagine. I felt helpless, and useless, and unsure what to do – for her, for her family or for myself.

The feelings I felt for Liza and her mother surely included feelings of one of Herman's criteria for trauma: helplessness. But I felt fear, not terror (Herman's second criteria) and even the sense of helplessness was muted or diffused because, I think, I could walk away; I could go home and not have to think about or deal directly with Liza's trauma and pain. But it is likely that the feelings tapped into my own early childhood experiences of trauma – they tapped into feelings of terror and helplessness. It's important to remember that, as others have said, trauma stays with us. It permeates our thinking. And as the reader will see, patients described in interviews describe strong reactions to what others might characterize as mundane or routine events.

That I remember and experienced those moments with Liza and her family as traumatic highlights the impact that being that child, or her sister, or her parents or her grandparents must have been like and what it must be like for them today. Trauma permeates one's thinking and one's behavior; it is head trauma.

> The residue of trauma is a kind of body memory, full of fleeting images, the percussion of blows, sounds and movement of the body – disconnected, cacophonous, the cells suffused with the active power of adrenalin, or coated with the anesthetizing numbness of noradrenalin.
>
> (Roberta Culbertson, in Aftermath)

While arguably traumatic, this indirect experience of sharing a traumatic event with friends was relatively passive. Another kind of trauma is, of course, the kind experienced directly by an individual. But psychologically, reactions to trauma, regardless of the form, tend to elicit similar reactions. “The human organism appears to work through trauma with a repetitive recreating of the trauma in flashbacks, dreams, and compulsive behaviors. As the mind defends its integrity by fighting in this way to stay whole, unwilling to move on in the present while unable to completely digest the past, we can see the roots of behaviors which have confused observers of human behavior for centuries.”(Bloom and Reichert, p.3) Whenever I see or hear about a sick child, I remember Liza and the way I saw her that day in the hospital. Whenever one of my children has localized pain (Liza’s first complaint) I worry about leukemia. And on a different note, I still have flashbacks and dreams about life with my stepfather. I know that much of my compulsive behavior stems from a need to control and manage an environment which was uncontrolled and unmanageable for so long.

As a child, one doesn’t know how or when the traumatic event or events are going to end – or start again. The child can’t control her experiences in that way. So part of recovery must be in taking control and creating a life with more predictability, more stability. Susan Brison argues, too, that recovery must include the ability to create more control over one’s intrusive PTSD symptoms, including memories, anxiety, compulsive behavior, etc. She argues that one needs to command mastery over one’s inner and outer

environment. Control may be the result of understanding, unpacking and working through the memories. Once they are understood it may be easier to absorb them, integrate them into one's mind and consequently not be as easily reactive to different triggers.

Not everyone would have reacted to Liza and her illness the way I did, nor would everyone have coped the way I did growing up in a hostile, violent household; this diversity is part of what's so interesting about looking at and thinking about a population of patients who have been victimized. "Traumatization occurs when both internal and external resources are inadequate to cope with external threat." (Vander Kolk, 1989, cited by Bloom and Reichert, p.4) "It is not the trauma itself that does the damage. It is how the individual's mind and body reacts in its own unique way, to the traumatic experience in combination with the unique response of the individual's social group." (Bloom and Reichert, p. 4) The trauma literature seems to argue, as do the clinicians whom I've interviewed, that people's responses to trauma are for the most part, individual. While I don't doubt that there is a great variety in how people react to stress and trauma, I also believe that there are similarities. Similarities may include feelings of distrust and worry, fear about many things, a wish and need to control one's environment, a sense of uniqueness or *specialness*. These characteristics are implicitly and explicitly stated in every relevant memoir and work of non-fiction I've read and in every interview and clinical interaction I've had with victims of trauma.

My stepfather is dead, but I was surprised on too many occasions – in our house, when he would show up at my schools in a rage, when, as an adult, I would find him outside my place of work, across the street in New York City, just staring at me as I left

work. And I continue to live with that low-grade anxiety that often becomes elevated – by different things and for different reasons. People who grow up with similar trauma histories may experience the same hyper-alertness and low-grade anxiety and worry; some may not, but I wonder about those who don't. What defenses are engaged by people and how are early childhood experiences enacted? How is anxiety controlled or how are symptoms manifested? I think about these questions in the context of my work with children, and I have learned to trust my instincts. In addition, what I have found from my readings, interviews, and clinical experience is coming together in a coherent package. People who have experienced profound trauma or series of experiences leading to cumulative trauma carry a particular burden. They live their lives, I think, with a sense of distrust and worry (granted, that manifests in different ways for different people) that can be exhausting. Patients with whom I have worked struggle profoundly with their vigilance, their need to keep their defenses in check, their lives in order, etc; it's serious business and it's hard work. They don't have much time or energy left for play.

I spent five years working as the school counselor at a competitive K-12 private school in New York City. While I had limited training at the time and felt largely unqualified to handle the responsibilities I inherited, there was one area in which always I almost always felt confident: essentially trusting my instincts. Citing Abram Kardiner, an expert on combat neurosis, Herman talks about a profound "hyper-alertness and vigilance" that develops in trauma victims – a hyper-alertness and vigilance that develops in an effort to sense and avert future danger. It's a result, she argues, of a chronic arousal of the autonomic nervous system that develops in trauma victims over time.

My intuition and perhaps a chronic arousal of my autonomic nervous system have alerted me to danger many times and I recognize this quality/strength/limitation in others. Having a sensitive trip wire can alert one to conflict and danger but it can go off too quickly or unnecessarily. Like many things, it's a compromise. A sensitive tripwire can lead to really valuable intuition and information, but it can also provoke arguments or keep one awake at night.

An example of the benefit of having a sensitive early-warning system while working at the X school in New York City is as follows: there was a situation with a particularly beautiful, soft-spoken, and cooperative first grader. She was a good student, had many friends and was remarkably serious. She was once described in a faculty meeting as "unusually studious and serious" for a first-grader – the teacher wished she "played more." Because of her obvious strengths I had difficulty convincing the teachers that there was reason for concern. But there was something about the way this child watched the people around her and watched her environment, and the way she moved and carried herself that concerned me. She looked like a child who had been hurt and was therefore watchful and careful in a guarded, self-protective way.

Trauma patients, Herman argues, "suffer from a combination of generalized anxiety symptoms and specific fears. They do not have a normal baseline level of alert but relaxed attention. Instead, they have an elevated baseline of arousal: their bodies are always on the alert for danger. They also have an extreme startle response to unexpected stimuli, as well as intense reactions to specific stimuli associated with the traumatic event." (1992) It was the way this child stopped – momentarily but completely – when someone entered or left the room, the way she startled with greater frequency than her

peers, and the way she watched people – as if she was waiting for something, that alerted me. “If children are exposed to danger repeatedly, their bodies become unusually sensitive so that even minor threats trigger off this entire sequence of physical, emotional and cognitive responses. They can do nothing to control this reaction – it is a biological, built-in response, a protective device that only goes wrong if we are exposed to too much danger and too little protection in childhood or as adults.” (Southwick, Yehuda and Giller, 1993 in Bloom and Reichert)

So I wasn’t surprised when this girl arrived at school one morning with a cracked and swollen lip, black eye and broken capillaries under both eyes; her father had hit her on the way to school because she “wasn’t moving fast enough.” He said he didn’t realize his blows would leave the marks that they did – finally providing proof of the violent and habitual abuse with which she lived. Because the family received intervention I do believe there was some improvement in the home situation, but I wonder often about this little girl (who is now well into adolescence) and about how the trauma has affected her. She was very young when she experienced what I later discovered was years of violence and abuse.

While some children may act out, other children may react differently. This child was remarkably calm and controlled, as if she was consciously attempting to keep herself together. I continue to wonder how much of her behavior was temperament and how much was learned as a result of positive objects in her world, or her need to control her behavior. “Children who are traumatized before their brains have learned the normal modulation of arousal are particularly at risk. This is part of the reason why the capacity of adults to soothe frightened children is so essential to their development. They cannot

yet adequately self-soothe. This is a capacity that gradually develops throughout childhood and adolescence." (Bloom and Reichert, 1998) Was this child overtly "good" and controlled because she was hyper-vigilant and watchful? Was it a defense mechanism learned to avert danger? What would happen if she let down her guard and allowed herself to be a feisty little girl? What happened the day she got hit on the way to school? My fantasy is that she was skipping down the street and stopped to look at something that interested her; her guard was momentarily let down and she took a blow – it was (in my fantasy) the last time she would play or be playful for a very long time. It was much safer to be serious and watchful – guarded. I wonder if and how she learned to play as an adolescent and what kind of adult she will become.

When I was on internship as a doctoral candidate, again working in a school, a teacher was sitting with me when a child came in to my office. He appeared at first glance to be only slightly agitated. To the teacher this child looked calm and in control, albeit somewhat unnerved. I had, however, an immediate and familiar physiological response to this child. I could sense his arousal. There was something about his posture, his body language, and his eye contact that alarmed me. I asked the teacher if she would move over a chair to give the child a bit more space in my office. He remained calm for another moment or two and I began by trying to speak calmly, quietly, in an attempt to decrease his agitation. He banged his fists on my desk and burst into rageful tears shouting that no one understood him, he was "outta here" and no one could stop him, etc. The teacher left my office, wide-eyed. Eventually this child became calmer, more in control, more regulated, but not before he had swiped or thrown everything except my computer off my desk and flipped two chairs. The teacher came back later in the day and

remarked on how this child is so unpredictable – that she never sees his outbursts coming. I did see his outburst coming (that is why I asked her to move over – to give him more space and to protect both of them.) I identify with this boy's anger and outbursts.

"One of the most serious harms of trauma is that of loss of control. Some researchers of trauma have defined it as a state of complete helplessness in the face of an overwhelming force." (Brison, P.73) Another way to conceptualize this is that the ego is overwhelmed. I don't know what set this boy off on that particular day, but I do know that he has experienced years of various forms of trauma. Brison argues that "memories of traumatic events can be themselves traumatic – uncontrollable, intrusive, and frequently somatic. They are experienced by the survivor as inflicted, not chosen – as flashbacks to the events themselves." (ibid, p.69)

Learning takes many forms. Bloom and Reichert (1998) stress how every experience involving danger that one has is ultimately connected to the next experience of danger, and so on. So with each experience we become more sensitive. So what are the implications of this?

Dr. Steven Elig, a psychiatrist and psychoanalyst in La Jolla, California, has supervised my clinical work since the fall of 2004. In a recent discussion with him about what actually happens to the body during periods of stress, he described the psychological and physiological responses to repeated stress in terms of "pattern recognition." He suggested that our brains are well adapted to scanning the environment and identifying familiar patterns. We do this so as not to be caught off guard by a stimulus that could have been foreseen given our prior experiences. Whether that stimulus is welcome or unwelcome, we prefer not to be surprised by it. This has several

consequences, one of which is that we might become sensitized to certain types of arousal and either sensitively and accurately predict danger or exaggerate the possibility of its occurrence. Another consequence is that we may unconsciously recreate the pattern of arousal in order to be actively in control of it rather than passively controlled by it. (Elig, personal communication)

If one lives in a world where her life is predictably unpredictable (for example, in the case of repeated trauma like that experienced by Annie Rogers, or Janette Walls or in the case of Susan Brison where her life was dramatically shattered the afternoon she was brutally raped) she would be desperate to know that she will not be surprised again. I can imagine patterns of arousal being ignited when one is surprised by anything different, whether dangerous or not. This could seem like a negative consequence, and is to some extent and for some people, but the excitement generated by stress, violence and danger is an intriguing component that is worth exploring.

Stress results in the release of endorphins. When people experience on-going or repeated stress or trauma, endorphins are produced and circulated at increased levels. In consultation with Dr. Elig I asked about the notion of becoming "addicted" to levels of endorphins and arousal patterns resulting in what appears to be a sense of feeling calm during periods of intense stress. He explained that the sensation of becoming "calm" at a time of increased stress may be due to the familiarity of that experience. The feeling may, indeed, feel like the effects of a narcotic and hence people use the "addiction" metaphor. But Elig prefers to explain this not in terms of an addiction but rather in terms of a patterned response to stress. At a time of elevated stress, he explained, there is a cascade of chemicals that activates the sympathetic nervous system and the fight-or- flight

response results. What feels like (and appears to be) a sense of calm may actually be a narrowing and heightening of focus related to the fight-or-flight response. The mind focuses intently on the perceived threat, and all other irrelevant stimuli are blunted. This may explain why a person who experiences a shooting may describe a slow-motion, "muffled" registration of the sights and sounds directly related to the threat with limited awareness of surrounding activity. This may serve to allow the subject to respond appropriately, even heroically, or it may serve to paralyze and anesthetize the subject. (Elig, personal communication)

I'm picturing it and thinking of it as a primal response to danger – how a deer stops suddenly when caught in the headlights or how a child who lives in a violent household might stop to gauge her surroundings and plan her next move before entering into the fray – or figuring out how to escape. But I still argue for the addiction metaphor – there is something remarkably intriguing and comforting about the feeling of "calm," which, like with a chemical substance, comes when one is not feeling calm (hence the need for the drug). It is, I believe, about mastery. There is something calming and soothing about the feeling of mastery…an almost grateful and euphoric, "ok, I conquered it this time…I'm safe for this moment."

I have always thought of my slowing down or calm reaction to stress or to trauma as "post-traumatic *delay*." The "delay" in anxiety, adrenalin and excitement (if it's suspended, focused or channeled in a different way) may allow one to become more clear-headed, methodical and careful, perhaps allowing for more thoughtful reactions or interventions. Herman argues a similar point, that "during stressful events, highly resilient people are able to make use of any opportunity for purposeful action in concert

with others, while ordinary people are more easily paralyzed or isolated by terror." (1992, p.58) It might be adaptive, but at what cost?

Terr writes: "traumatized children recognize profound vulnerability in all human beings, especially themselves. This shattering of what Lifton and Olson call the 'shield of invincibility' and what Erikson terms 'basic trust' and 'autonomy' appear to characterize almost all event-engendered disorders of childhood." (Terr, p. 14) This is one of the potential costs.

Living with Trauma

In addition to Drs. Herman and Terr, the work of the following three women in particular has dramatically affected my thinking and work with regard to this thesis: Dr. Annie Rogers, Janette Walls and Dr. Susan Brison. Dr. Rogers, an adjunct professor and researcher at Harvard, wrote A Shining Affliction, a memoir which focuses initially on her work with patients as an intern in a clinical psychology doctoral program and then details, dramatically and painstakingly, years of horrifying sexual abuse at the hands of her mother and father. She discusses how, through the course of her internship working with a young traumatized boy, she suffers a psychotic break and only through intensive treatment regains her strength and her ability to re-enter clinical life – and to regain her life as an intact person.

Janette Walls wrote, The Glass Castle, a memoir describing her nearly unimaginable experiences as a child living in extreme poverty with an alcoholic father and mentally ill, but brilliant mother. Ms. Walls, despite no formal early education and after enduring years of shocking experiences (profound emotional abuse and neglect, being homeless with her family for months at a time, going on “pervert hunts” - chasing down men who tried to sexually assault her as a young girl - with her brother (age 8) armed with bats and an axe, etc.), managed to find the strength and courage to move to New York City and to get herself enrolled at Barnard College. After Barnard, she lived with her fiancé in Manhattan as her parents joined the ranks of the NYC homeless (by choice) and regularly rifled through garbage cans in her affluent Upper East Side neighborhood.

Dr. Susan Brison, author of the memoir, Aftermath, also profoundly influenced this study. Dr. Brison, professor of philosophy at Dartmouth College was brutally raped and left for dead while on vacation in France one summer several years ago. In her memoir she shares not only her experience of the trauma, but also her recovery process and thoughts about treatment. In addition, her research on trauma theory and therapeutic interventions provided a wealth of information relevant to this study.

What is it like to be someone who suffered trauma at an early age? While people may respond to stress and to trauma in their own individualized ways, there are also examples of overlapping symptoms and of those who exhibit similar symptomatology who live with daily stress but who have not experienced trauma per se.

“A traumatic experience impacts the entire person – the way we think, the way we learn, the way we remember things, the way we feel about ourselves, the way we feel about other people, and the way we make sense of the world are all profoundly altered by traumatic experience.” (Bloom and Reichert, p.5) And for the person who lives with repeated trauma, and repeated abuse, it can become all - encompassing. Bloom and Reichert stress that when trauma occurs in childhood, not only does the child have to deal with the specific consequences and sequelae resultant from the trauma but also, depending on the nature and duration of the trauma, there can be long-standing consequences on the child’s development. “Children who are exposed to repeated experiences of overwhelming arousal never develop normal modulation of arousal.” (ibid, p.7) Children who grow up in homes in which violence – verbal or physical – is the norm, especially if it’s unpredictable, have the hardest time. “The result is that they’re chronically irritable, angry, unable to manage aggression, impulsive and anxious.”

(Bloom and Reichert p.7) These children look for anything to soothe themselves because they've learned they can't depend on their parents, who are often the source of the danger – either directly or by not protecting them. Later these are the adolescents and adults who turn to substances and behaviors to self-soothe- drugs and alcohol, sex and food. (Bloom and Reichert)

One can only cope with a "certain amount of stimulation or excitation at any one time. This depends on the degree of maturity of the apparatus. If it is exposed to too great a quantity of affective energy it can be overwhelmed, i.e., the normal stimulus barrier can be breached. In childhood the immature apparatus is more prone to be overcome by a sudden influx of stimulation, (i.e., energy that the child is unable to regulate by appropriate and controlled discharge along normal channels." (Models of the Mind, p. 49)

Childhood trauma can derail development and may interfere with myriad areas of functioning, including peer relationships and attention and focus in school. When a child is worried about or focused on what's happening at home or what is going to happen at home, it's very difficult to concentrate on typical developmental concerns and milestones. How could a child have time to think about or process much else?

"Whatever is learned when we are frightened gets attached to the fear 'file drawer' in our minds. Whenever fear is triggered again, that is the file drawer that is accessed and no other file drawer can necessarily be opened." (Bloom and Reichert, p 11) We learn to access this file drawer, we learn, over time, to respond to situations in various ways. But a critical factor for understanding a person who has suffered repeated

trauma is that “learning is dependent on the sate of consciousness we are in when we learn.” (Van der Kolk, 1989, in Bloom and Reichert, p.11).

In Aftermath, Brison, quoting Locke, sites the following: “Locke talked about the kind of development of the self in terms of a set of continuous memories and a kind of on-going narrative of one’s past that is extended with each new experience.” Brison expands this by arguing that “the study of trauma presents a fatal challenge to this view since memory is so drastically disrupted by traumatic events.” (p.49) Losing parts of one’s history or past is not inconsequential. I doubt one can avoid feelings of a loss of control associated with a loss of memory. This is a critical and powerful treatment issue.

I am just learning, first hand, some of the cognitive, emotional and physiological responses of post-traumatic memory difficulties. In a recent consultation with a psychoanalyst, she asked me to think back to some early childhood memories. While I have explored early childhood memories in myriad contexts including in past treatments and in different contexts while in graduate school, this exercise was more focused, more in-depth, very specific. I was not only stunned by my lack of ability to recall early memories (I can’t access the name of one teacher before 5th grade, nor can I recall the names of most of my teachers between 5th and 9th grades, for example) I became increasingly anxious and flooded as names and dates involving important events were lost or dramatically confused prior to about 1992 - when I was twenty-six. Brison writes, “not only are one’s memories of an earlier life lost, along with the ability to envision a future, but one’s basic cognitive and emotional capacities are gone, or radically altered as well. This epistemological crisis leaves the survivor with virtually no bearings to navigate by.” (p.50) This is a scary crisis. Brison refers to the symptoms resulting from the crisis

as "autonomy-undermining." (p.50) To suddenly become flooded and totally overwhelmed by feelings generated from a loss of control – a lack of understanding of one's life, to lose time, lose facts about one's history, can feel devastating. It's not only potentially autonomy-undermining, as Brison writes, it can create a feeling of being out of control. This lack of control can attack one's sense of agency and competence. It can add a new dimension to feeling "special."

If one can't remember, because of memory deficits, processing difficulty or due to a defensive splitting off of unpleasant, scary, intrusive memories or due to one's psychic energy having worked so hard to compartmentalize events and feelings, there is a problem. If there is no capacity (or little) to remember school facts, names and dates or events, then perhaps even one's ability to process her story is damaged or destroyed.

> Memory is an action: essentially it is the action of telling a story.
> Pierre Janet

Not being able to remember, having memory gaps, can create feelings of incompetence and failure. And in many cases, "no matter how brave and resourceful the victim may have been, her actions were insufficient to ward off disaster." (Herman, p. 53) So she's living with the feeling of guilt and failure. Traumatic events by definition, thwart initiative and overwhelm individual's competence. (Ibid. p. 53) These symptoms sound pretty dire, and they can be, and yet many survive with a great deal of competence and resilience. "Guilt may be understood as an attempt to draw something useful from disaster and to regain some sense of power and control. To imagine that one could have done better may be more tolerable than to face the reality of utter helplessness." (ibid., p. 54) And "shame is a response to helplessness, the violation of bodily integrity, and the

indignity suffered in the eyes of another person…In the aftermath of traumatic events, survivors doubt both others and themselves. Things are no longer what they seem." (Herman p.53)

"Living with the feeling of failure," sounds like blaming the victim. And while I certainly don't believe that it's her intention to convey this, it's an interesting point to pursue. Feelings of guilt, inadequacy, and failure are the antithesis of feeling strong, powerful and special. Perhaps this explains, in part, some of the contradictions seen in the patients of my interview subjects. I was consistently surprised by a contradiction in the patient's profession and their characterological descriptions. Examples are the social worker who has never had a love relationship, the psychologist who "shuts down to use her strength to move forward," and the physician who is profoundly anxious and suffers from OCD and depression. And then there are the patients who are described as both counter phobic (get into people's faces and fight with people) but also warm, gentle, and creative. These are all high functioning patients who also seem confused, conflicted, ambivalent, and they seem to struggle profoundly; there is a lot of conflict.

So these patients may learn that they need to protect themselves. There may be a sense that develops in those patients who are lucky (characterologically strong, creative, resourceful, those who find mentors, etc.) that they need to watch for danger. If they succeed they feel strong and special – perhaps this is about healthy narcissism.

Treatment Issues

> The worst fear of any traumatized person is that the moment of horror will recur, and this fear is realized in victims of chronic abuse. (Herman, p.86)

Brison is a strong proponent of treatment – individual and group therapy and of taking openly about traumatic experiences. "Having people listen, the survivor begins not only to integrate the traumatic episode into a life with a before and an after, but also to gain control over the occurrence of intrusive memories." (p.71) And talking is being proactive. Victims of any kind of trauma need an opportunity to exert power and control, to take the stage and to be in charge. As painful as it can be, giving voice to one's pain has to create a sense of release

A lucky few receive treatment; many don't. Perhaps the most eloquent and convincing argument I have read for treatment is that one must be able to put words to traumatic events. "Without words, everything is in the ever present *now*. Words allow us to put the past more safely in the past where it belongs." (p. 10, Herman) But if we assume that to do this we must talk with others, we must find people, or at least someone, to talk *to*. In the trauma literature, the most salient issue for trauma patients seems to be the issue of trust: trauma victims have difficulty trusting people and forming lasting connections. When one has been hurt, violated, especially by someone she knows, it is hard to believe that it won't happen again. When the experiences of trauma or victimization are repeated, the ability to trust gets harder. "Traumatic events destroy the victim's world, the positive value of the self, and the meaningful order of creation."

(Herman, p. 50) I would qualify this, somewhat, as I do not believe that traumatic events always destroy the victim's world, but it is reasonable to say that they can destroy parts of the victim's world and aspects of the self. A rape survivor, Alice Sebold, states, "When I was raped I lost my virginity and almost lost my life. I also disregarded certain assumptions I had held about how the world worked and about how safe I was." (ibid, p.51) And a patient should feel safe in treatment.

So what can a therapist do to help the patient form attachments that feel safe? "The survivor, who is often in terror of being left alone, craves the simple presence of a sympathetic person. Having once experienced the sense of total isolation, the survivor is intensely aware of the fragility of all human connections in the face of danger. She needs clear and explicit assurances that she will not be abandoned once again." (ibid, p.61) What I believe Herman means when she talks about the victim having experienced "total isolation" is a result of not being rescued. Perhaps it is easier for an individual to feel alone or isolated as opposed to feeling seen but ignored – as if only someone knew about her plight she would be rescued, but because no one knew, she was subjected to the misery alone. But then having to be alone, I imagine that one may develop a sense that she does not need or want others and then consequently pushes people away. And this can feel powerful.

The theme of hyper-vigilance that can comes with victimization and experiencing trauma may be critical to understanding one's feelings of a need for power and control. Being vigilant can lead one to "see" before others see and to "see" things that others don't – just by definition of being more watchful. But if one watches, is vigilant, and can avoid a problem, or rescue another before disaster strikes, a feeling of power and a sense

of being powerful might emerge. But there is little time to play if one takes on this role. For to play one must be able to withdraw from or suspend reality, one's guard must be let down. But this could be dangerous, like the first grader who may have let down her guard for a moment on the way to school and then got hit, hard. So she, I can imagine, instead of allowing herself the luxury of being playful again, instead developed into a sentinel; she became a watcher. My fantasy is that from that point she watched, ostensibly protecting herself and others, from real or perceived danger to come. And in so doing, she might have learned to read body language, to gauge people's affect, to read people and her surroundings, far better than her peers. This might have made her feel powerful, and it might have made her feel special. A key treatment issue, I believe, is to help these patients integrate and accept and embrace the role of the sentinel and learn how to play, and to be playful, too.

Play

Defining Play

Solnit, author of *A Psychoanalytic View of Play*, argues that there is “no generally accepted, comprehensive definition of play.” (p.205) Peter Neubauer, author of *The Many Meanings of Play*, argues that “the attempt to define play, leads either to a concept so broad that the borders between other mental and physical acts disappear, or one so narrow that its usefulness is limited.” (p.3) But Neubauer does go on to talk about three components of play: “a mental act, a conscious or unconscious thought with fantasy and wishes, and an observable enactment.” And a third quality of “trying on” or an “exploration, an attempt to resolve a problem in order to achieve a new level of competence or developmental organization.” (p.3) The defining component, he argues, is that the participant in the play realizes that the play is not *real* – the participant can differentiate the play from the reality.

Play involves imagination, fantasy play, trying on different roles and having objects and people acting, role-playing, enacting different personalities and scenarios. (Neubauer; Solnit) “When play goes ‘out of control,’ and the play is the same as – not the opposite of – reality, it is play.” (Solnit, p.212) For example, when children play but the nature of the play shifts – the little boy’s dinosaur gets “trapped” or “hurt” by his friend’s dinosaur which is the attacker, the stakes become greater. Children can regress when playing and shift into id mode and the fight between dinosaurs becomes passionate and real vs. playful.

Solnit talks about this shift for adults with sexual gratification: “As the degree or level of stimulation and gratification rises, the suspension of reality decreases; the

pretense is lost in the reality of the sensuous experience. Masturbation may start as play, but as the intensity of the stimulation and gratification increase, quantitative changes build up to qualitative changes of experience. Then the relationship of the ego and id in play is changed." (Solnit, p.208)

Colarusso looks at the differences between childhood and adult play and argues that because development is an on-going process through adulthood, play may serve the same function in adulthood that it does in childhood – "promoting the engagement and mastery of phase-specific developmental tasks." (Colarusso, p.225) Colarusso argues that there are similarities and differences between adult and child play which he says is "a reflection of the evolution of psychic structure and developmental process throughtout the life cycle." (ibid, p. 230) "As the capacities of the ego grow and life experiences multiply, play becomes 'an indirect approach to seeking an adaptive, defensive, skill-acquiring, and creative expression. It is a mode of coping with conflicts, developmental demands, deprivation, loss and yearnings throughout the life cycle." (Solnit, quoted by Calarusso, p.226)

Plaut argues that play has not had a significant role in the adult psychoanalytic literature due, he argues, to Freud's early belief that play is largely restricted to childhood play. Freud argued that in the course of development, play is "replaced by fantasy, transformed into creative activity or subordinated to the reality principal." With Freud having claimed that adults do not play, even though he later modified his statement somewhat, Anna Freud (1965) went on to say that the play of childhood is later replaced by *work* for adults. Anna Freud believed that the shift from play to work happened during the latency period when "due to the increased ability of the ego to (a) control impulses

and use materials constructively; (b) delay gratification and carry out preconceived plans; and (c) achieve the transition from primitive instinctual to sublimated pleasure and from the pleasure to the reality principal."

Greenacre, in summarizing Waelder (1932), wrote that the psychoanalytic theory of play includes "instinct of mastery; wish fulfillment, assimilation of over-powering experiences according to the mechanism of the repetition compulsion; transformation from passivity to activity; leave of absence from reality and from the superego; and fantasies about real objects." Other erudite definitions include: "play activity in adulthood reveals the masterful mature function of the ego, which temporarily dominating id and superego, integrates their components into ritualized expression with a structured, articulated framework" (Plaut, 1979). Ostow (1987) argued that play is "freedom from expectable consequences that is enjoyed in the moment and not carried over into real life." Colarusso takes issue with this and argues that there *is* carryover into real life citing the use of repetition of themes in later play. So certainly "role playing" for adults is just that – *playing* a role, ostensibly to practice or to pretend to be someone else for periods of time. For example, pretending, or role-playing with a friend or spouse to be a sharp-tongued, witty employee, arguing for a raise, allows one to practice and to refine one's argument for a conversation in real time.

Play allows for a release, and a retreat. But if, as Herman, Terr and so many other theorists say, symptoms resulting from a vast and prolonged trauma history (or even from a single event, as Brison argues) occupy or affect one's thoughts and get in the way of healthy functioning, how do these people play? Perhaps this population plays more cautiously. Perhaps it is a luxury to play in the same carefree manner that some do.

Verbal play, verbal sparring, comes to mind as a “safe” form of play. This form of play may emerge in therapy and enable trauma patients to experience a release, a respite, a retreat (as well as a playful and potentially fun exchange with another) from the burden they may feel during their daily lives.

For Winnicott, play is the area of experience between subjectivity and objectivity. The transitional object is an object that bridges the space between the subjective experience with the mother and the objective experience of the world. Play (in childhood), according to Winnicott, leads to shared play and later (in adulthood) to cultural experiences. Transitional objects are bridges, giving one the confidence, perhaps, to venture out, take a risk and decide to play with another. I think of it as giving one the courage to play with a new idea or concept – whether going to sleep on one’s own (a child) or, perhaps, sharing one’s home or things with another in adulthood to help bridge a connection – to encourage play and interaction among adults.

Play is a difficult concept to define succinctly. Various authors have contributed to this effort by emphasizing the components, meaning, function or affect of the activity which we might recognize as play. Taken together, we may have a lengthy but useful definition.

Other Aspects of Play

> Play provides a mechanism for disengaging from frustration and disappointment in the real world by providing an illusory gratification which reduces tension and distress. Second, play also provides relief from intra-psychic conflict by offering pleasurable alternatives. But most importantly of all, particularly for the adult, play seems to provide, not for the unrestrained pursuit of pleasure, but rather for the exposure to realistic or realistic-like challenges, the overcoming of which relaxes tension and replaces it with pleasure…play is a simulated, attenuated and controllable reality. When the pain becomes too great, or the threat too formidable, the play can be terminated. (Ostow)

Play, for both children and adults, according to Colarusso, "relieves the stress of living in reality and the frustration of basic conscious and unconscious needs; it provides a mechanism for confronting a challenge and overcoming it in a gratifying manner." (p.226) Play also serves to help people create, build and grow friendships.

"Play ceases to be play when the child (or adult) loses his ability to stop when he wants to do so, when he becomes glued to one phase, to one episode. Play then becomes a phobic defense." (Peller, p.180) Play ceases to be play when the capacity to pretend is lost. (Colarusso)

Colarusso argues that when adults play, they do so for the same reasons as do children: "to contain and organize their inner world – their intra-psychic lives of drives and conflict in an effort to understand themselves and to portray themselves in favorable ways to others." But what about playful sparring?

Andatto wrote about the importance of looking at the *choices* of play in adulthood. Instead of doing what many do, which is look at "child's play" or to assume that adult play is simply recreating or re-working past experiences, he argued that "play should be considered a lifetime activity of the human being, and that its latent

unconscious meanings rather than its manifest structure be used as a basis for understanding and comparison" (in Colarusso p.237) This is interesting with regard to assessing choice of games or play for an adult. It makes me wonder, particularly, for purposes of this paper, how a study in itself might be to examine conscious and unconscious choices of play and games (including the interest in spectator sports) for adults.

Modell talks about another kind of play – the use of metaphor. He looks at the importance of re-contextualizing and playing with memory and meaning; thus the importance of metaphor. Metaphor, he argues, "allows for a play of similarity and difference, resulting in a complex perception of feeling." (p.147) He continues by saying that traumatized patients can suffer from cognitive deficits and lapses resulting in the inability to use metaphor. Modell believes that it is the ability to re-contextualize memory that determines how one will respond to trauma. If one cannot re-work or recontextualize a problem, the experience will remain in the present and serve to inform all that comes in the future. The past, he argues, becomes a template for the present. Memory needs to be played with and manipulated in order to digest and work through it. The result, Modell argues, for memory and experiences not being re-contextualized or assimilated is that, as Freud argued, the individual unconsciously deals with the memories by "enacting the unconscious memories or meanings resultant from them." (Modell, p.164)

The capacity to be playful and the importance of being playful in a treatment relationship are remarkably absent from the therapeutic literature (adult literature) and in the training of therapists working with adults. When I began my pilot interviews for this project, invariably analysts to whom I spoke (even though I explained the protocol and

repeatedly talked with me about their treatments with *children*. Assuming they were listening to me and genuinely wanted to be helpful, I understand this in a couple of ways: 1) when they think of the concept of play in the context of their treatments they automatically think of their *child* patients, foreshadowing the likelihood that there are clinicians who find it difficult to talk about play (or being playful) in a therapeutic context; and/or 2) that it triggered something in them that was triggered in me the day I walked out of my own therapist's office and decided, "I don't play."

I think as adults most of us focus on being "adult-like." What that connotes for me is: thoughtful, professional, responsible, trustworthy, etc; "playful" isn't a word that immediately comes to mind. I think of *children* playing and when adults play with children they can be playful, but it's in reaction to being with children and moving at their speed, playing at their level. Adults can be verbally playful, or can "play," (a game, a sport), but it's still not a word that immediately comes to mind. And when I *do* spend time thinking about it what does come to mind is playful sparring (verbal) and "playing" with someone – playing a role or pretending in a playful way, but this often has a dark twist. An example I've talked about with friends and colleagues for several years since moving to California involves being asked repeatedly to give my name at Starbucks. I often (I haven't completely grown out of it) give someone else's name. It irritates me (on some days more than others) when I'm asked my name. It's an intrusion. It connotes, for me, a false sense of connection and familiarity which annoys me; so I give different names.

I recently had dinner with a colleague of my husband. This topic came up and, without hesitation and with little affect this colleague (male) said, "yesterday I said my

name was Doris." Everyone at the table laughed, and someone asked if he was kidding. He wasn't. His body language and affect, while very subtle, alerted me to something - I think this guy is very angry – about what I obviously don't know. And of course I could be wrong. His discussion on the topic was very funny, and playful, but I think he has a story; and I wonder about it. Does he feel powerful and special when he gives a fictitious name? What entitles him (or me for that matter) to do that? Is it power or a crack in our armor? Does it connote power and entitlement or vulnerability or both? The class clown is often masking profound insecurity or vulnerability. Controlled, calculated play that is not free, easy, light-hearted or spontaneous (Greenacre) may be the "play" of choice for trauma victims. Who knows if this guy with whom my husband works has a trauma history? But I do wonder about him, about what defines him, and I think about him now in a different way.

The literature is full of relatively benign and ubiquitous statements like, "trust is a key issue in the therapeutic alliance," and "a feeling of safety is critical for the therapeutic connection…" there is little that is interesting or playful with regard to the issue of trust or safety. By "interesting" or "playful" I mean something that intrigued me, something I could associate to and have fun with; something…anything dramatic or sexy. And when I started thinking about *that* – the need or desire for something dramatic or sexy, I realized that while there can be dramatic, intriguing and sexy elements associated with trusting someone and to feeling safe with someone (a lover, one's child at times) trust and safety is, I think, about that which is knowable, stable, unchanging (perhaps), solid, secure, and probably *not* dramatic, intriguing or sexy. When you trust someone or feel safe with him or her, you might feel special – elevated – empowered – special. *Then*

you can take risks. When you feel safe you have the foundation to take risks. If the ground beneath you is shaky, the focus has to be securing a stable foundation.

But to develop a meaningful relationship requires the ability and desire to risk rejection, embarrassment, loss…The dilemma for many people who have experienced trauma is that some are loath to take risks, and some (like a former patient who was repeatedly traumatized and victimized - sexually as well as verbally - for many years), take exaggerated risks. This patient became a sex addict who had unprotected sex with strangers on a regular basis. How do we understand this? What role does play have in these people's lives? Do the people with an aversion to risk engage in only structured, well-calculated or controlled play - like board games or team sports with well defined rules, while the uber risk-takers engage in whatever comes their way, and crave spontaneous pleasure? Are the non-risk-takers more or less likely to fantasize and to play out their desires in *that* way while the risk takers are more likely to *act* on their fantasies? And what about all the people in the middle – who play and take calculated risks for pleasure's sake – scuba dive with a seasoned instructor, break away from teammates and opponents with a ball during a soccer game, or decide to go to a party with the knowledge that she won't know anyone there? And where do these decisions come from? "Very little has been written on the subject of adult play or on the relationship between adult play and its childhood antecedents." (Colarusso, p. 225)

Therapeutic Alliance and Play

> The everyday play of childhood…is free and easy. It is bubbly and light-spirited whereas the play that follows from trauma is grim and monotonous…play does not stop easily when it is traumatically inspired. And it does not change much over time. As opposed to ordinary child's play, post-traumatic play is obsessively repeated…post-traumatic play is so literal that if you spot it, you may be able to guess the trauma with few other clues. (L. Terr, author of Too Scared to Cry in Judith Herman's Trauma and Recovery)

The capacity to be playful and the importance of being playful in a treatment relationship are remarkably absent from the therapeutic literature (adult literature) and in the training of therapists working with adults. When I began my pilot interviews for this project, invariably analysts to whom I spoke (even though I explained the protocol and gave them written documentation of the study) repeatedly talked with me about their treatments with *children*. Assuming they were listening to me and genuinely wanted to be helpful, I understand this in a couple of ways: 1) when they think of the concept of play in the context of their treatments they automatically think of their *child* patients, foreshadowing the likelihood that there are clinicians who find it difficult to talk about play (or being playful) in a therapeutic context; and/or 2) that it triggered something in them that was triggered in me the day I walked out of my own therapist's office and decided, "I don't play."

Modell, a psychoanalyst, and author of Imagination and the Meaningful Brain, argues that in our lives we all select people - objects - who will provide meaning for us and who will help us work through and change experiences from our past and develop new relationships and experiences in our futures. One such relationship is the relationship between a therapist and patient.

One hopes that a positive connection, or treatment alliance, develops between a patient and her therapist, thus facilitating the beginning of what Chethik would call a new libidinal attachment. The therapeutic alliance is a new object relationship “through which developmental experiences involving play may be revivified and, ultimately, may lead to the forging of more enduring and successful adaptations.” (Chethik, p.9)

Within the treatment context, a patient is able to share feelings and feeling states, wishes and fantasies and to “let go” of certain inhibitions thus allowing for a freer exploration of the unconscious. The treatment alliance is created or at least enhanced, Chethik argues, by the development of a shared understanding by shared stories and interpretations, shared games and meaning between a patient and her therapist. (Chethik, 2001)

A significant turning point in the treatment of a disturbed trauma patient (and training case) with whom I worked for several years came when we shared a particularly funny moment in the treatment – a moment at my expense. We were talking about some issue I claimed emerged the previous week. The patient, I thought somewhat flippantly, remarked that it hadn’t happened the previous week because I had been on vacation. I corrected him, explaining that I had not, in fact, been on vacation the previous week, when he interrupted me, and somewhat agitated, exclaimed, “you *were* on vacation last week – check your calendar.” Without arguing further (thank goodness) and after a considerable pause, I did check my calendar and saw that the patient was right; I *had* in fact been on vacation the previous week. I brushed over the gaff, embarrassed, and was temporarily unable to confront my mistake. Several power struggles led up to this session and I could feel the patient’s agitation mounting with this exchange (not surprisingly). I

didn't know how to deal with the conflict. Moments later we were talking about scheduling and the patient asked for a scheduling change. My spontaneous response was, (with a sigh and some eyeball rolling) "I'm pretty sure I can make the change, but I'd better check first; maybe I'm on vacation…" The patient paused briefly and, knowing I was making a joke, burst into laughter. I laughed too, and the tension in the room lifted instantaneously and considerably. Quite by accident I had used play and humor as a treatment intervention. I believe that the use of humor in a playful way (and using myself as the focus – instead of the patient which could be an indirect confrontation (Cohen) led to a breakthrough in the patient's defenses and served to neutralize some of his anxiety and aggression thereby strengthening the treatment alliance. The use of humor and playfulness made me more real, more human, and allowed me to poke fun at myself in a way that showed I, too, have limitations. Following this incident, we were finally able to look at and explore some of the power struggles with which we had been dealing.

Analyst A1, when describing play in his treatments with adults talked about shared joy between his patient and him: "generally I would expect there to be a sort of – joyful affect that's going to be generated during play. It's an affect that's infectious to all the players." "Infectious" is a wonderful word choice. When something infects you it seeps in and is absorbed and permeates your being. Infectious laughter feels terrific; shared humor and playfulness in the treatment alliance is, I believe critical. Once the treatment alliance is established and the transference deepens, therapist and patient are better able to look at and to "play with" the material of the treatment.

Many questions remain for me about ways in which a particular kind of patient traumatized in childhood copes with her history and about how her symptoms manifest in

her treatment. I developed the semi-structured interview to pull for anecdotal information from practicing clinicians to help me explore the functioning of these patients and to look at ways in which play and playfulness enter their lives.

Trauma and Play

What permeates and dominates the trauma literature is information about ways in which a person's psychology and biology are affected when one is subjected to extreme and/or prolonged stress and trauma. Many people exhibit symptoms connected with increased anxiety and can have significant issues with trust and safety which can lead to problems in any kind of relationship – e.g. between parent and child, spouses, friends and co-workers. Even though these people can clearly grow up into productive adults and can and do have lasting, healthy relationships with others, it appears that many of us struggle – sometimes in profound ways.

And while the literature on adult play is not as voluminous as I had hoped or expected, common themes do emerge: themes around freedom of expression (verbal and physical), a suspension of reality allowing for greater creativity and exploration, and play as a vehicle for re-working one's past and anticipating the future.

What is absent in the literature, but very relevant to this study and to understanding trauma patients, is the extent to which people who experience trauma can develop a profound sense of power which can lead to a sense of specialness and an identification with being special.

I have gathered a robust understanding of what it's like to live with a trauma history (an academic understanding which compliments my own personal knowledge). In this thesis (with the help of psychoanalysts I have interviewed), I wish to be able to share additional findings about the effects of trauma, the importance of play and the ways in which play is used by trauma patients and can be used by therapists to facilitate growth in the treatment of victims of trauma.

Focus of the Study

The focus of this study is to examine a particular population of people (adults with early childhood trauma histories) and to gain insight into their series of experiences, to look at ways in which they have managed (and continue to manage) those particular experiences and then look at ways in which the experiences have altered and shaped their lives. Over the course of the research I have continued to wonder about the use of and importance of play, playfulness and humor in the context of understanding and working with these patients. An early hypothesis was that humor and a kind of careful or thoughtful verbal playfulness or back and forth in the treatment situation could enhance the treatment alliance which could then lead to greater insight and understanding into the patient's life. As we learn more about how these patients understand their experiences and ways in which their lives have been affected plus strategies and tools they have used to cope, we as clinicians are better able to treat them.

Methodology

Subjects

The principal subjects in this study are psychologists and psychiatrists who are also psychoanalysts or psychoanalytic candidates. They are all practicing clinicians and have treated patients recently or are currently treating patients who make up a specific population: adult patients who grew up in families that they (the patients) describe as being marked by extreme and/or habitual violence. The patients are the secondary subjects. Nine primary subjects (five male and four female) were interviewed and several were contacted for follow-up exploration.

Procedures

The initial set of questions was designed to explore the concepts of trauma and play and ways in which these concepts might manifest in a psychological context. These questions were piloted with dynamically-oriented therapists. The pilot study conducted with two therapists gave rise to additional questions which assisted in the development of the semi-structured interview used in this protocol.

The semi-structured, in-depth interview protocol (Appendix A) was designed to explore with practicing psychoanalysts the following: 1) the analyst's understanding of and beliefs about the concept of play and playfulness – in general and with regard to their treatment with patients; 2) the analyst's understanding of and thoughts about what play and playfulness means in the treatment – what are ways they might be playful and when, what are ways analysts need to be wary of "playing" with their patients in a pejorative sense; 3) how they would describe their understanding of their patient's understanding of

his or her subjective experience of play; and 4) what are ways in which these patients play or experience play and playfulness differently from patients with different early histories. This interview protocol had many iterations.

The study was described to prospective subjects as "an exploration" of the notion of play and playfulness with regard to trauma patients. Each potential subject was informed that approximately one hour would be required for the in-depth clinical interview. The subject was informed that an additional follow-up interview at a later time may be requested which he/she could agree to or not, and it was explained that the interview would be audio-taped and later transcribed verbatim for research purposes. It was explained that names and identifying characteristics of the subjects would be disguised and that the subjects were encouraged to do the same with regard to their patients (the secondary subjects). Each potential subject was told that he/she would be given a consent form (Appendix B) which would outline and document the protocol and procedures. If the therapist had a patient come to mind that fit the protocol and if he/she agreed, an interview date was scheduled at that time.

Each interview was conducted in the private office of the interview subject. Mental notes of the office space were taken to add to the body of data from the interview. The topic of the research and the interview protocol was reviewed with each subject. Two copies of the release form (one for the therapist to keep for his/her records) were given to each subject and time was allowed for it to be read. After the subject signed the release form and asked any questions, the audio equipment was set up and tested. The interview protocol was followed and paper and pencil was used as a back-up measure. In addition to hand-written notes regarding the affect, body language and tone of the interview

subject, notes were made by the principal investigator with regard to thoughts, feelings and reactions to the interview subject and to the material presented. Each interview was transcribed verbatim within twenty-four hours of taping. Each transcript was discussed and analyzed in weekly conferences.

After the first few (3) interviews had been conducted, data was observed that gave rise to particular themes and additional questions. After two additional interviews and more supporting data, important new themes emerged: specifically, themes involving the notion of specialness and vigilance (concepts to be more clearly defined in the results section). Phase I data (gathered from interviews 1-5) gave rise to Phase II of the study which consisted of extending the interview protocol to incorporate questions to get at the nature and importance of specialness and vigilance.

Phase II data collection consisted of a revised interview protocol (Appendix C) conducted with subjects 6-9. Follow-up discussions with clinicians gave rise to additional sub-themes and topics and concepts related to the concepts of trauma, play, specialness and vigilance.

Phase III of the study consisted of follow-up interviews conducted with five of the nine original interview subjects. The rationale and purpose of the follow-up interviews was to ask several of the original interview subjects (from Phase I) questions about the concepts of specialness and vigilance (which had not been explored in the original interviews) and to assess their view of the importance these concepts played in the lives of their patients.

The methodology employed to examine the data was primarily content analysis. Each transcript was analyzed by examining the narratives with meticulous focus. How

the primary subjects described their patients and answered questions and mused about their patients in the context of the interview protocol was examined. Next, an attempt to cull out the manner in which relevant concepts (trauma, play, specialness, and vigilance) were described and then analyzed as were sub-types within the broader concepts to explore similarities and differences, and overlap or lack thereof. In addition to the four primary concepts explored, the importance and relevance of the secondary subject's relationships and attachments were looked at as was the use of a defensive strategy referred to as "retreating." (Steiner, *Psychic Retreats*) And in addition, one way in which all nine secondary subjects have the propensity for handling aggression (through provocation) was also explored. Whenever possible, ways in which the data connect, overlap or stand alone have been noted in the results section and then explored in the discussion.

Results

The following consists of brief biographies of each psychoanalyst (primary subject) and his/her patient (secondary subject) whom he or she discussed during our interview. Identifying information has been disguised to the best of my ability.

A1 is a psychologist and faculty member at a prestigious medical school on the east coast; he supervises graduate students from several graduate programs in his home city. He has been a practicing psychoanalyst for more than ten years. His affect and demeanor were calm and professional during the interview process and he was clearly very comfortable and engaged during the interview. There was shared laughter and good rapport between this subject and me.

A1 described his patient as a bright woman who is a social worker by training. She grew up in a physically violent and verbally abusive household. A1 reported that "her mom was, quite frankly, sadistic." And prior to the parent's divorce (the patient was 8) her mom was neglectful and had quite a rough manner of discipline toward the patient, but most of her sadism and most of her abuse was directed toward her husband. And after the divorce, the patient became the target so it became a dangerous situation for her until she left her home."

A1 described his patient's interest in social work as a vehicle for providing for children in a way she was not cared for as a child. He described her as "altruistic and counter-phobic in terms of dealing with her early demons." (A1) This patient is "morbidly obese" and has never been in a love relationship. She does not have any children. A1 described her overeating and excessive shopping as her "anger and

aggression turned inward." This patient is very "verbally facile, playfully taunting in treatment and despite all her difficulties, exudes a sense of specialness."

A2 is a psychiatrist and psychoanalyst in private practice on the west coast. While she has completed her analytic training, she is chronologically young and new (less than ten years) to the field. She practices in her home with her two dogs present in the treatment room which is also her library. While she presents as warm and engaging, she also appears somewhat scattered and disorganized (manifested as being confused by her appointment schedule, temporarily distracted by her phone ringing with her answering machine not turned off, etc.).

A2 seemed very eager to accommodate me on this project and was extremely generous with her time (went over time despite having a patient waiting). There was an ease to the interview process.

Patient 2 was described as a practicing psychologist who is married to a "depressed history teacher with whom she has very little physical contact." They have one child together. This patient grew up in a "very chaotic, very abusive" household; the patient was one of ten children. Patient 2 both witnessed and experienced extreme and habitual physical and sexual abuse. The violence was "parent to parent, parent to child, and sibling to sibling." (A2) A2 described how one of the patient's brothers (an alcoholic - as was the father) "would get into horrible, bloody, knock-down fights. The father would drink daily and would often come home and wake the children up and beat the mother up in front of the children and would threaten to do the same to anyone who tried to come to her defense…he would have them marching around the house at 3:00 in the morning." (A2)

On the weekends when the mother would go out shopping the father seduced his daughters. "He would have them come into bed with him one at a time. He would fondle his daughters and have them fondle him. My patient remembers looking forward to that attention from her father and didn't realize until she was an adolescent and was talking with friends that it was something not good that was happening to her."

"She was also set up by her father with her father's brother when she was young. She was raped by her uncle. In addition, her own brother fondled her as well as set her up with his friends to be…to have her body used by his friends. She was very young. It wasn't intercourse, but it was a lot. So there was a lot of violence, chaos, abuse…in the family of origin." (A2)

This patient, as an adult, had an affair with an older, "paternal figure" with whom she felt safe. A2 describes her patient as having "very constricted affect" and of frequently "freezing up, shutting down and shutting off," but explained that this has become less debilitating over time. (A2) A2 described her understanding of this phenomenon as that the patient had to in childhood "shut down to use her strength to move forward."

A3 kept me waiting for more than twenty minutes. His office was dark and austere, with several very phallic items (a wooden tribal statue holding a sword, mounted martial arts fighting sticks, and artwork depicting tall, angular buildings) displayed in his waiting room. His office was similarly dark – with regard to lighting and feel. A west coast psychiatrist who has not yet completed his analytic training, he talked in a boasting, patronizing way about my wanting to make sure that I interview analysts with "extensive training backgrounds." A3 made it eminently clear to me who was in charge by

frequently interrupting the interview protocol, veering off on irrelevant tangents and by cutting me off and dismissing me before the end of the scheduled appointment time. I experienced this interview as a one-way dialogue with very little reciprocal play.

A3's patient is an accountant in a large west coast-based insurance firm. He grew up in an abusive household with an alcoholic father who "beat his mother up and also beat him up." (A3)

A3 talked about the fact that his patient's girlfriend complains of a "lack of intimacy" in their relationship. This patient does not have any children. He argued that his patient doesn't trust people and that the patient is afraid of his anger, and often becomes "flooded." A3 also talked about a sense of "specialness" with regard to his patient.

A4 is a psychiatrist in private practice and new to the faculty of a west coast analytic institute. Her affect was warm and engaging and her office was light and airy, full of pillows and soft, inviting furniture. While A4 was welcoming and respectful of my task, she lacked the intellectual edge and quickness of the first three subjects. There was dullness and consequent slowness to the interview process.

I was, however, struck by A4's ability to talk patiently and with passion about her patient's tendency to "freeze up" at times in the treatment while at the same time she seemed incapable (as a result of being unaware, perhaps) of describing this process as flooding – which it may or may not have been.

A4 described her patient's trauma history as follows: "her father was physically and emotionally abusive toward her and I think the mother was very passive and didn't intervene and didn't protect her. She was terrified of her father as a kid. But on some

level she also felt like she was the favorite and she also feels like she got stuff from him…He flew into irrational, unpredictable rages and was, as I said, was frequently emotionally abusive but also physically. And just the terror she felt over time…" (A4)

"This patient is enormously creative, but in the course of treatment I know that we kind of bump up against these walls that feel so anxiety-provoking. I'll say something or ask a question and she'll just sort of 'freeze up' and it's such a sudden shift in her capacity to play…" (A4)

She also described her patient as "provocative" ("she got in her father's face and stood up to him in very provocative ways") after years of abuse. This therapist said that her patient feels "special" as a result of being the oldest in her family and because she "got stuff" from her father – "special stuff" – sexual attention, pleasure and attention – warranted, wanted, pleasant or not - attention. A4 experienced the patient's standing up to her father as counter-phobic. "He was potentially dangerous, but the feeling I got from her (which she communicated) was a 'don't fuck with me' attitude, a 'you can't fuck with me anymore,' feeling." A4 said that through the course of treatment as they talk about difficult issues "it's a very sudden feeling – like I feel like I'll walk into something not even realizing it and her back will go up…and I just feel like this feels dangerous, and the space shuts down." "The creative, more playful space – her back goes up and it feels much more brittle and rigid and I feel much less free – I feel like I have to be careful." (A4) "She has a lot of anxiety and is often overwhelmed with managing her life." This patient is a writer and was not in a love relationship at the time of treatment. She has one child from a previous marriage. The patient shares custody of her young child with her parents.

A5 is a psychologist and senior analyst affiliated with a prestigious analytic institute on the west coast. He is also an adjunct faculty member and supervisor for a well-respected graduate program in clinical psychology. A5 was quiet and soft-spoken. Intense and cerebral, the subject also presented as somewhat critical and suspicious of me (asking twice how the patient's identifying information would be disguised). There was a lack of warmth and a lack of ease in the room that was palpable. I felt self-conscious and rushed to complete the interview protocol.

A5 described his patient as a physician, mother of three who began seeing A5 while she was in medical school. "The picture she paints is that her father was violent, especially when he was drunk, which was frequent, and his violence was directed at the mother, the older sister or the brother; never toward her. She was his precious, golden child. They had something 'special.' Then what emerged pretty quickly, I think, was the concern that she had been sexually abused by her father. Over time I'd say that that has become a conviction and there's a lot of reason for her to have the conviction. Her mother was also physically violent toward her – more sporadically and not when she was drunk, and I don't think she drank heavily, but there was tension that was sometimes marked by violence on the part of the mother." (A5)

This patient developed OCD at age thirteen, obsessively wringing her hands and biting her nails. She was seriously depressed at age fifteen and unable to continue with school at that time and for some time after. Married to an abusive man and divorced while in treatment, her husband gained custody of all three of children. A5 talked about an early lack of solidity exacerbated by trauma and yet talked about her feelings of

"specialness." "So messed up as it may have been by sexual abuse, she loved her father and felt he loved her in a way she needed, and nobody else did." (A5)

A6 is a psychiatrist and senior analyst working in private practice on the west coast. She was warm and engaging, immediately putting me at ease. She was professional and respectful in her interactions, alternately asking questions about and showing support for the project and interview protocol. A6 became interested in and focused on her patient with regard to the protocol almost immediately and genuinely seemed to enjoy musing about her in the context of the interview. The exchanges with me were animated and playful and I had the experience of a rich dialogue with her.

At the time of the interview, the patient of A6 was a homemaker expecting her first child. As a child she endured years of verbal and emotional abuse at the hands of her father and stepmother exacerbated by the emotional separation and loss of her mother who ultimately rejected her by leaving the home when she was a young child. Before her father's death (when she was a teenager) her role in the family was to be vigilant about what *he* needed and about what was going on with *him* and in what ways she could guarantee focus on *him*. (A6) Her anger and aggression manifests as "getting into a ditch" with people – she fights with people. We talk about getting into a ditch with her husband's children and fighting for her husband – losing her adult status and losing the fact that he chose *her,* impregnated *her*, he's sleeping with *her*, etc. It's a need to build up her sense of specialness, maybe." (A6)

A7 is a psychiatrist and senior analyst working on the east coast. He presents as very cerebral, highly intellectual and a bit stilted with regard to his affect. A7 was clearly very professional but lacked warmth or ease. It was as if he sees and talks about his

patient as an object, a "case," as opposed to a person with whom he spends time in a treatment context.

A7 described his patient as a woman who grew up with a psychotic mother. He explained that this patient's character structure is formulated around a sense of suffering – that her suffering is "usually characterized by her need to see herself as being victimized by someone else's meanness, by someone else's inability to understand her, by someone else's sadism." (A7) And in part due to the mother's psychotic depression and consequent frequent absence from her life, the patient "developed compensatory mechanisms that principally involved her belief that it is her responsibility to take care of everyone." (A7) This patient has a profession "in medicine." It is not known whether she was in a love relationship with someone at the time of the interview or if she has children; it is presumed that neither is the case.

A8 is a senior analyst practicing on the east coast. While I have had numerous experiences working with A8 in the past and have always experienced her as incredibly anxious and concerned about what people "mean" by things they say to her, I experienced her in the context of the interview as relaxed, gracious and very generous with her time.

A8 described her patient as a sixty-three year old woman who has been in analytic treatment (with a variety of therapists) for most of her life. A8 reported that she was sexually abused by two of her analysts, a third killed himself and a fourth died in a car accident. In addition to these traumas she was raised by a psychotic mother diagnosed as having a borderline personality. This patient has never been married nor does she have any children.

A9 is a senior training analyst working on the east coast. He seemed genuinely intrigued by the topic and eager to participate in the study. His affect was calm but engaged and his demeanor was almost excessively relaxed manifested by almost lounging in his chair with his feet up.

A9 described a patient who is in her early fifties and has a profession in "the helping professions." She has two grown children and, at the time of the interview, was in a relationship with a man whom she was in the process of leaving. This patient was sexually abused as a young child by a male family member living in her home. She was later (at age eleven) abused by a teacher who "fondled her genitals." This patient was reported to have a "wonderful sense of humor" and is "very playful." (A9) She was also described as "fundamentally religious."

This sample of subjects (and patients) is limited. The primary subjects are all extremely well educated, highly trained clinicians who are all affiliated with prestigious psychoanalytic institutes. It is not an accident that they have patients who are highly educated, smart, engaged and engaging, high functioning and with the ability to pay for intensive psychotherapy treatments or analyses.

I began this study intending to explore how trauma (loosely defined) affects one's capacity for play (loosely defined). I wasn't sure what I would find and while many of the results are unsurprising, many interesting data points have, indeed, surfaced. In order to make the results and discussion chapters more meaningful, I have attempted to define, (with the following table and result's chart to refer to for clarifying purposes) as clearly as possible, what I have come to mean when I use constructs like trauma, play, vigilance and specialness and what I mean when I talk about "attachment," the defensive strategy

of “retreating,” and what the meaning of being “provocative” is for this patient population. I will begin by talking about the kinds of traumas this patient population has experienced (as reported by their therapists) and follow with how a sense of specialness, attachment and vigilance are described as well as how the concept of retreating is described. I will follow with examples of ways in which these patients were described as provocative by their therapists and then come full-circle with ways in which these patients were described by their therapists as playful – or not. In the discussion chapter I have explored somewhat more fully what the definitions of these constructs mean to me and what they mean in the context of the research.

Functioning of Mother

A9: distant mother
A2: defenseless mother
A4: passive mother

A5: cold/absent mother
A6: physical and emotional loss of mother
A3: passive mother

A1: violent mother
A7: psychotic mother
A8: psychotic mother

Specialness

A9: Oedipal victor
A2: late "Oedipal victor"
A4: father's favorite

A5: Oedipal victor
A6: Oedipal victor
A3: Oedipal victor

A1: specialness comes from suffering
A7: specialness comes from suffering; also special to father
A8: special attachment to psychotic mother

Vigilance

A9: (didn't resonate)
A2: internal vigilance – but kept under wraps
A4: (didn't resonate)

A5: paranoid – people against her
A6: vigilant re: needs of her father
A3: vigilant re: needs of his mother

A1: paranoid and vigilant at night
A7: vigilant re: needs of her mother
A8: paranoid with expectation of abuse

Attachments

A9: solid attachments
A2: lack of intimacy, but evolving
A4: struggles with intimacy – difficulty connecting with child

A5: difficulty with relationships – gave up custody of children
A6: uncomfortable needing others
A3: intimacy issues

A1: solid attachments at work, but nowhere else
A7: unhappy and miserable in all relationships
A8: difficulty sustaining relationships – detaches

Retreating

A9: (didn't resonate)
A2: "shuts down to use her strength to move forward"
A4: "her back goes up and the space shuts down"

A5: lost in fantasy
A6: retreats in fantasy
A3: retreats by creating "non-relationships"

A1: retreats by using drugs and alcohol
A7: retreats by using literature
A8: previously retreated into fantasy and now her mind

Provocative

A9: sets limits by telling people off
A2: attacks husband verbally
A4: got into father's face – fought back

A5: shopping binges
A6: fights and "gets into the ditch" with people
A3: inferred: "rescuing" mother may have provoked father

A1: provocative with therapist – provocative calls, suicide threats
A7: oppositional
A8: alienates people

Play

A9: playful – with capacity for play
A2: limited capacity, but evolving
A4: creative and playful, but back will go up

A5: verbally playful, but otherwise, no
A6: very inhibited, not playful
A3: no play in the transference

A1: verbally playful, but otherwise, no
A7: can’t play
A8: early fantasy play but nothing else

The patients, or secondary subjects, in this study have suffered from myriad abuses. Three of the patients (described by A2, A5, and A9) suffered from being sexually abused, two by their fathers (patients of A2 and A5) and one (patient of A9) by a family member living in the home. Six patients (those of A1, A2, A3, A4, A5 and A8) witnessed and experienced extreme and/or habitual violence in the home (with patients of A2 and A9 also suffering from sexual abuse). Patients of A7 and A8 suffered as the result of living with unpredictable, psychotic mothers (with the patient of A8 also experiencing violence in the home). And the patient of A6 was described as having been traumatized as the result of the early loss of her mother. This loss was due to a bitter custody battle and then exacerbated by years of emotional torture at the hands of her stepmother and later as a result of her biological mother's rage once the children had the opportunity to be reunited with her.

In addition to these various forms of trauma and abuse, through the course of the study an additional element of trauma began to emerge: the consistency with which (in all nine interviews) these patients had mothers who did or could not provide consistent, safe, nurturing holding environments for their children.

Two mothers were described as "passive," (mothers of patients of A3 and A4), and one (mother of the patient of A2) as "defenseless." "Passive and defenseless" I understand to mean that they neither protected themselves nor their children in reaction to abuses suffered. The mother of A9's patient was described as "distant," with the mothers of A5s and A6's patients described as "cold and/or absent." The mother of A5's patient was also violent, as was the mother of A1's patient. The patients of A7 and A8 suffered from having psychotic mothers. Later, in the discussion chapter, I will describe some

thoughts I have with regard to the connections and relevance between the functioning of the mothers and the functioning of the patients described.

In addition to the functioning of the patients' mothers, there are additional patterns with regard to other early attachment figures - most notably the fathers: of the nine patients described, the therapists described seven of the nine as either "Oedipal victors" (patients of: A2, A3, A5, A6, and A9) or as the father's favorite (patients of A4 and A7). It was in this context that the therapists described their patients as "special" or exuding a sense of specialness. A1 and A7 described their patients' specialness as coming from the fact that they had suffered – that there was a moral superiority connected to the fact that they had suffered from abuse and had been victimized. The patient of A7 was also, however, described as her father's favorite and "special" to her father. A8's patient was described as having a "special" attachment to her (psychotic) mother whom the therapist added, "manipulated her early idealization."

In the context of this study, "attachment" refers to the patient's comfort with and connection to others. The patient of A9 is the only patient for whom "solid attachments" across the board were described. The patient of A1 was described as having solid attachments at work, with her patients, but nowhere else. A6's patient was described as being uncomfortable with relationships, manifesting as having difficulty needing others. Three patients were described (patients of A2, A3 and A4) as having "intimacy issues" and two (patients of A5 and A8) as having "difficulty maintaining or sustaining relationships." A7's patient was described as "unhappy and miserable" in all relationships.

“Vigilance” was defined or talked about in several different ways. A2 described her patient as experiencing “internal vigilance” which, she explained, the patient “keeps under wraps” a lot of the time. The patients of A3, A6 and A7 were all described as being vigilant with regard to the needs of their parents (the needs of the mothers in the cases of patients of A3 and A7 and the needs of the father in the case of the patient of A6). These patients were vigilant in terms of watching to make sure that the needs of their parents were met in order to keep (the patient) safe. A1, A5 and A8 described patients who are “paranoid” and vigilant in that they watch out for fear that people are “against” them or “out to get” them. The concept of vigilance in reference to their patients (in any form) did not resonate for either A4 or A9.

With regard to the concept of “retreating,” A2 and A4 talked in a similar way about how their patients retreat in treatment when the material becomes difficult. A2 described how her patient “shuts down to use her strength to move forward,” and A4 described how her patient’s “back goes up and the playful space (in the therapy) shuts down.” A5, A6, A8 and to some extent, A7, all talked about how their patients retreat” into fantasy when things become difficult. A7 talked about his patient retreating with literature, which may be a similar defense. A1 described how his patient quite literally retreats or leaves by medicating with drugs and alcohol. And A3 described a different sub-group of retreating: retreating or pulling back from relationships by creating “non-relationships.” The concept or construct of retreating did not resonate for A9 with regard to his patient.

Each therapist gave a different definition of the way in which his or her patient is provocative. A9 described his patient as provocative in terms of “setting limits by telling

people off." A2 described how her patient "attacks her husband verbally." A4's patient "got into her father's face" as an adolescent – she "fought back." I don't have evidence to support whether or not she is still provocative in this manner.

The patient of A5 goes on shopping binges to get back at her husband, and the patient of A6 fights and "gets into the ditch" with people. A1's patient is provocative with him by leaving provocative phone messages, including suicide threats. The patient of A7 is "oppositional" in a provocative way and the patient of A8 "alienates people" by being verbally provocative. With the patient of A3, the provocation is inferred when A3 talks about his patient's rescuing of the mother as perhaps being provocative to the patient's father.

The construct of play and playfulness, while described in somewhat individualized ways among the therapists with regard to their patients, appeared to follow patterns consistent with patterns of other attributes. The groupings of patients into categories remained consistent across categories and attributes (appendix D). A9 was the one therapist who felt that without question, his patient is playful and has the capacity to play. He described her as "verbally playful" and with a "great sense of humor." He described her as "playful" with her children, her husband, and friends and with him. A2 described her patient as initially (when she entered treatment) having had a very limited capacity to play, which has evolved into a more fluid, and flexible capacity over time. A2 explained that through the course of treatment her patient has become more "playful and flirtatious." A4's patient was described as "creative and playful" but with the qualifier that "her back will go up and the playful space shuts down" when she is pressed on an issue or in the face of stress or anxiety. A1 and A5 described patients who are verbally

playful but who are not playful in any other way. A6 described her patient as “very inhibited and serious” and not playful, and A3 described his patient as “not being able to play in the transference (the only way in which this therapist was able to think about the term). A7 explained that his patient “can’t play – that she lacks spontaneity, is self-punitive, neither playful in the real world nor in fantasy.” And last, A8 described how her patient’s early play was fantasy play with her brother (in childhood) but that now her ability to play is “very impaired.”

Discussion

During this research protocol several patterns emerged. My hope and intention is that readers and therapists with whom I discuss this project will benefit from thinking about where their patients and future patients might fit into these patterns and groupings in addition to thinking about what a patient's individual constellation of conflicts might be.

For this particular patient population, although it is a small sample, I have been able to trace a path from the early trauma to an upbringing (on a continuum) of less than good enough parenting. Patterns emerged with regard to Oedipal situations which appear to provide a window into how patients appear later in life in relation to several different attributes: how a sense of "specialness" is experienced; what the patient's attachments and relationships to others might be; the relevance of vigilance in the lives of the patient; how the defensive strategy called "retreating" might manifest; and at least one way in which the patient's aggression might be expressed. And then, as a result of the research, we can look at the construct of play with regard to this patient population and the ways in which it might speak to the patient's overall functioning and ways of working in therapy with these patients.

First we need to consider at what the patient's earliest experiences might have been. Winicott wrote extensively about the critical importance of a child's early environment. He said that an environment must be "adequately" reliable and that one's mother must be "good enough" (1965b). The *sine qua non* of healthy development for Kohut is the extent to which the mother is attuned to and mirrors a range of affects and moods for her child. Kohut believed that the mother's ability to metabolize and to feed

back a range of emotions for her infant is critical for healthy development. (Kohut, 1971) Through mirroring, the mother accurately reflects the child's moods and needs and eventually the child internalizes the mother as a positive self-object representing the range of her psychic life. If, however, the mother fails to represent some aspect of the child's functioning, the child will experience this part of herself as bad or unacceptable and this part will be split off in order to stay in relationship with the self-object and others. When the mother reflects only her own desires or needs, the child is forced to hide or deny parts of herself because she experiences them as bad or unacceptable. The child becomes reliant on positive mirroring and praise and feels rejected and cut off when the self-object's needs (and later the needs of others) override her own needs. (Kleiger)

What happens when the child's affective states are disrupted by trauma? What happens when the child desperately needs the mother or caregiver to accurately mirror the child's experience and to calm the child through selective mirroring techniques but the mother is incapable? What happens when the mother or caregiver is incapable of soothing the child because the mother herself is overwhelmed? We see from the research that was gathered that children appear to suffer in profound ways and maybe (although we cannot say this with certainty given the size of the sample) more than those children who suffer the same or similar trauma but have more stable mothering experiences.

Winnicott, too, talked about the importance of the mother's ability to accurately mirror the child's affects and moods which he believed leads to the infant experiencing herself as authentic and real thus leading to what he called the development of the True Self. (Winnicott, 1965b) He argued that maternal connection and attunement is critical for healthy development to take place. (ibid.) The infant's self is strengthened and

develops by her needs being met (her id impulses satisfied) as a priority over the needs of the mother or the environmental situation – versus the child being forced to conform to the needs and wishes of the mother. Winnicott called this "good-enough mothering." Good-enough mothering represents the mother's capacity to hold the infant "sometimes physically and all the time figuratively." (Winnicott, 1965b) "The good-enough mother meets the omnipotence of the infant and to some extent makes sense of it. She does this repeatedly. A True Self begins to have life, through the strength given to the infant's weak ego by the mother's implementation of the infant's omnipotent expression." (Winnicott, 1965b)

Through "holding" and as a result of the mother's attunement (which Winnicott called "optimal responsiveness") the child begins to see herself as a separate object with others having separate needs and wishes. From this understanding emerges the realization that one's needs can't always be met. This realization facilitates the development of reality testing and allows the infant to gradually abrogate omnipotence and to develop the capacity to depend on others which Winnicott called "usability." And without the holding, mirroring and affect attunement, the infant is forced to deny and split off feelings and needs because to acknowledge them would leave the infant in an intolerable state. This denial leads to ego weakness and ultimately to the development of a False Self. Another way to think of this is that in order to manage feelings that aren't being held and managed by the good-enough mother, the child denies her feelings and adopts new ones and new ways of being with the mother which leads to the development of the False Self and False Self bonds.

Masud Khan, in an article on trauma, discussed his thesis of cumulative trauma as being the result of the mother's lack of ability to act as a "protective shield" for her infant. He argued that the mothers' role is to act as an auxiliary ego in order to support the immature ego functioning of the infant. He argued that specific breaches in the mothers' ability to act as a protective shield aren't responsible for trauma, it is, rather, the cumulative effect of the mother's failures (Winnicott called these cumulative failures "impingements") to provide this protection that is problematic. (Khan, 1963) And certainly we saw this in the research.

Khan described the notion of a protective shield as a theoretical construct looking at not only how a mother interacts with her infant but how she manages the environment in which the child spends time – plays, sleeps, etc. (Khan, 1963) I've spent much time discussing the importance of the early attachments to the mother, because it appears that the mothers of the patients described neither managed their everyday affective needs through accurate and empathetic mirroring nor acted as a protective shield, shielding them from internal affective states and states generated by environmental stressors – at least not consistently, and most likely not during times of trauma. And this, coupled with the identified trauma itself may have led to a lot of the difficulties experienced by the patient's in this study.

The research is organized and outlined as follows: the table found on pages 67a and 67b shows patients one through nine (indicated by their therapist's interview numbers e.g.: A1-A9) and how they group with regard to seven variables. For example, I have first listed the type of abuse each patient experienced then listed horizontally the functioning of each patient's mother as described by the patients' therapist. Next, the

table lists horizontally how playful or not (and ways in which the patient manifests playfulness) the patient is, etc. After tabulating that data, I summarized it in a second format found on pages 68-70. These pages group the data in the same way (by type of abuse and each category in succession as found in the table) but show the data in groups of three. The amount of information we have permits me with a certain degree of confidence to divide the patients into three equal groups. While I would need more information to make more nuance, and specific claims about the data, the information I have does allow me to examine the patterns and groupings in general terms.

The first group (consisting of the patients of A9, A2, and A4) is always the first group, or group "A." The second group (patients of A5, A6, and A3) is always the middle group, or group "B." And the third group (patients of A1, A7, and A8) is always the last group or group "C." Group "A" represents the highest functioning group – those patients who, in my opinion, appear to be the healthiest and highest functioning group. The "C" group represents the lowest functioning group or those patients who seem to have the most consistent difficulty in life. And the "B" group represents the middle group and those patients who fall between the other two groups based on functioning and perceived (loosely defined) health.

It was interesting to me and revealing that the data could be clustered in this way and that the same patients fell into the same categories or groupings on every variable. For example, A9, A2 and A4 could be grouped together in group A with regard to every category and the same is true for the other two categories. And while the sample is too small and not enough data was generated to rank the patients in order of "health" or to rank them consistently within each category, the patterns appear consistent.

With regard to the first category, or “functioning of the mother,” it appears from the data that the functioning of the mother has the potential to greatly influence the relative health of a patient. For example, while even the highest functioning group (A group) still appears to have a difficult time in life, (those patients had distant, defenseless and passive mothers), the C group, or the group with the most apparent difficulty in life, also suffered from having violent and/or or psychotic (and probably the least healthy) mothers. It is logical to me and would be supported by Winnicott’s and Kohut’s theories, that those patients with the violent and psychotic mothers would fare less well than those patient with passive or distant mothers.

When the concept of “specialness” or these patients feeling or exuding a sense of specialness emerged in the early part of the research, it surprised me. Once the data emerged I hypothesized that the sense of specialness (in spite of the victim status of the patient) would be linked to important people in the lives of the patients - role models such as teachers, an important family member, or a friend’s parent who cared about the patient in a special way. I assumed that there would be a link between, “I’m worth caring about, and, “I’m special.” Another early hypothesis was that these patients would feel special as a result of developing and honing “special” skills - skills leading to or fostering self-preservation. An example is the post traumatic “delay” I personally experience at times of stress which I believe allows me to be more clear-headed, methodical and careful, hopefully leading to more thoughtful reactions and interventions. Herman, has talked about how people are often stunned, leading to near paralysis at times of stress, whereas some, who are more resilient, tend to make more thoughtful and careful decisions. (Herman, 1992)

According to the data, the most important factor leading to a feeling of specialness in this sample was that of being an Oedipal victor. Five of the nine patients were described as “Oedipal victors” by their therapists with the patient of A2 achieving this status in a slightly different way (later in life she met and had an affair with a supervisor and parental figure which may have led to her sense of specialness). A4 was described as her “father’s favorite” but not specifically as an Oedipal victor. And even A7 and A8 were described as special to their parents. The Oedipal or special status with a loved parental figure is interesting and certainly similar to my hypothesis about the importance of role models and mentors. But of course these relationships are also spoiled by definition of having won the love of the opposite sex parent at the cost of being the rival of the same sex parent. And then the relationships are further spoiled by the violence and abuse in the homes of these patients. The patients in groups A and B were all described as Oedipal victors or in the case of A4, her “father’s favorite.” The C group had patients who fall into two different groups; those whose specialness comes from an identification with their suffering – “I have suffered, therefore I am special” (there appears to be moral superiority that is linked to specialness for these patients) and specialness in the case of A8 which came as the result of an enmeshed relationship and attachment to her psychotic mother.

I saw the most individual variation among the patients described in terms of attachment, but there is still consistency among the groupings. Group A’s patient of A9 was described as having solid, positive attachments with family, friends and co-workers. The patient of A2, while described as having difficulty with intimacy, was also described as evolving in this area of functioning and seems to be making considerable progress.

The relationship she had with the older, paternal figure may have provided her with a sense of specialness leading to confidence which has helped her become more flexible and playful. Her therapist described her becoming more playful and flirtatious as a result of her attachment to this man.

The patient of A4, who is also part of the "A" group category, appears to have many of the same issues with intimacy and attachments as those patients in the "B" group. Those patients in the "C" group seem to have much more profound difficulties with attachments and connections than those patients in the other two groups. Even the patient of A1 who manages to have solid relationships at work with her patients is not able to form or sustain relationships outside of work. And the patients of A7 and A8 appear to have even greater difficulty. These difficulties appear to be linked to problems in the early attachments with the patient's mothers.

So how do we understand how some of these patients manage to have connections to some or in some contexts but not others? A1 talked about his understanding of his patient's ability to sustain relationships at work but nowhere else as being the result of work being very structured and contained and providing the safety that is lost elsewhere. This patient is also determined to provide for children the safe connection and attention that was so lacking and distorted in her own early childhood. She may be re-working and repairing her own experience through her work with these children. Perhaps this patient channels her focus, interest and strengths into her work and then when the structure of work falls away (at home) she finds herself less focused, perhaps more vigilant, but channeled in a different way and with the loss of structure comes the loss of ego strength and resilience. Vigilance negatively channeled morphs into paranoia and pathology.

The area of vigilance looks very different in the research data than I expected. I expected that therapists would describe how their patients have heightened sensory systems, that their patients watch out for and expect danger (Herman, 1992) but not necessarily to the extent that it impairs functioning all the time. The concept of vigilance did not resonate at all with two of the three therapists of the A group patients and the third therapist described her patient as exhibiting "internal vigilance" which she "keeps under wraps." (A2) At the opposite end of the spectrum are the patients in the C group who are described as vigilant to the point of being paranoid, and vigilant in a way that impairs functioning most of the time.

I do wonder if the therapists in this study are overlooking or undervaluing the positive aspect of vigilance, which could explain why it is absent in the research data. For this patient population, vigilance could have been their survival strategy. By being watchful and vigilant these patients (and other victims of trauma) could possibly avert potential danger and develop a sense of power and control as a result of learning to be watchful and self-protective. I think it is also possible, even though this did not come up in the data, that a pattern of watchfulness and vigilance (and an interest in watching and being vigilant) may have influenced the career choices of the patients in the study. Two of the three patients in the A group (A1 and A2) are in the helping professions with the third (A3) an outlier as an accountant (may speak to heightened defenses and a propensity for warding off feelings and emotions). A5 in the B group is a psychiatrist, A4 a writer and A6 a homemaker. In the C group, all three patients are in the helping professions.

Another interesting (and related) finding in the study is the extent to which these patients "retreat" in treatment. The psychoanalysts interviewed, with tremendous

consistency (A2, A3, A4, A5, A6, A7, and A8), describe ways in which their patients "freeze up," "check out," "shut down," or "retreat" in treatment. A4 talked about "bumping up against walls that feel so anxiety-provoking. I'll say something or ask a question and she'll just sort of freeze up, and it's such a sudden shift in her capacity to play."

A2 talked about this phenomenon in an intriguing way. She said her patient "*shuts down to use her strength to move forward*." John Steiner describes patients freezing up or shutting down as "psychic retreats." "A psychic retreat provides the patient with an area of relative peace and protection from strain when meaningful contact with the analyst is experienced as threatening." (Steiner, p. 1)

In 2001 I wrote extensively about a trauma patient with whom I was working for several years. I experienced the patient as often "retreating" (he would avert his eyes for several seconds in an almost frozen daze) in treatment. I understood in terms of him becoming overwhelmed by the connection or by the material that we were working with. The retreats happened frequently when we discussed relationships with this patient's family and when we touched on our relationship in a meaningful way.

Sheldon Bach talks about a "freezing" symptom in a similar way. "The traumatized infant who is bombarded with stimuli and overwhelmed with anxiety is unable to respond spontaneously and has lost all sense of agency. At best he can learn to respond mechanically to the world. At the beginning of an analysis with a very traumatized adult, he may often try to eliminate all naturally occurring rhymicities and to 'freeze' the analytic situation into a rigid mode that will guarantee against further discontinuity and trauma." (Bach, 1991, p. 107)

Steiner argues that progress is often achieved after a retreat. A retreat can be seen as a way to exercise control when the patient is feeling out of control. It is adaptive in this way as it is a way for the patient to put a stop to regain control. Like A4's patient, these patients somehow learn that they need to "shut down to use (their) strength to move forward."

The concept of retreating did not resonate for A9 with regard to his patient. Both A2 and A4 describe what may be a similar defensive strategy used by their patients: the idea that in the face of stress or difficulty, the "playful space shuts down" (A4) For A2, her patient "shuts down to use her strength to move forward." These strategies are quite likely protective devices to defend against flooding or at least against dealing with the stressors directly. The patients in groups B and C were described consistently as retreating in potentially much more damaging ways into fantasy (an escape from reality) and in the case of A1, by using drugs and alcohol.

Perhaps retreating is a counterpoint to managing stress or conflict with anger or aggression. For this patient population the most consistent way in which aggression was discussed was in the context of provocation. The A group seems to respond to situations with a kind of controlled provocation. A9 described his patient as "setting limits by telling people off." A2 described how her patient chooses her husband to "attack verbally." And the patient of A4 "got into her father's face" and finally fought back when her father provoked her which could be a reasonable and adaptive response. The patients in group B were described in a ways that appear somewhat more problematic; "shopping binges" (patient of A5), "fights and getting into the ditch" with people (patient of A6) and by provoking his father by "rescuing" his mother and by being an Oedipal victor, in the

case of the patient of A3. The group C patients were described as making provocative phone calls and suicide threats to her therapist (A1), being oppositional (A7), and being provocative to the point of alienating people in profound ways. (A8)

Why provocation? Perhaps these patients simply have pent up aggression that needs release. Brison talks about the loss of control and helplessness that trauma patients can feel (Brison) which could, when an opportunity to take control emerges, cause one to be impulsive and provocative for similar reasons – to release anger and tension in a safe or seemingly safe environment. The patients in the A group seem to achieve this better than do those in the C group for whom their provocative behavior appears to be less adaptive. Bloom and Reichert talk about children who grow up in violent homes exhibiting behavior that is angry and impulsive, anxious, and prone to irritation. I can imagine how a certain amount of anxiety and irritation and certainly angry feelings could lead to impulsive and provocative behavior.

A4 described how her patient's father flew into "irrational and unpredictable rages" and that her patient described feeling "terror." But then as an adolescent she discovered that she could "rebel against him and did, big time. She got in his face and stood up to him and was very provocative with him." I wonder whether this ability to stand up to her father comes from a sense of entitlement and specialness or if it could have led to a sense of specialness? It can feel very powerful to be provocative; it is an exhibition of strength – if even temporary. Perhaps, even if it provides a temporary and even false sense of power and strength it is worth it to these patients. And maybe it's a more primal response to danger – a way of communicating (even from the weaker, less powerful person) "don't mess with me; don't risk it because I'll attack you. You may be

bigger and/or stronger but I'm tough and I'll take you on." Another question I have is whether or not provocative behavior is reparative, problematic, or perhaps both. When the ego is overwhelmed, it needs a form of release. Without release or a means of release, one is trapped. So perhaps if someone is able to regulate her emotions and affect enough to release the pent up feelings of anxiety and anger, irritability and rage, she can be provocative (as in the case of A4) in a way that is reparative. But if she becomes deregulated and out of control, the provocation with certain people or in certain venues can lead to problematic outcomes.

And we probably all have examples of ways in which provocation can have a playful feel to it. Playful banter, poking fun at someone, teasing, can all be playful but also can, at any moment, assume an edge. When someone crosses the line by saying something slightly hurtful or embarrassing, or when affect becomes charged or body language suggests it's no longer play, things change quickly. And then playful taunting or teasing becomes provocation with a very different connotation and feel.

The data from the research showed the following with regard to play: most of the trauma patients discussed for this study can *not* play. Groups B and C show patients who were described as unable to play. A5 in group B and A1 in group C talked about their patients who, while verbally playful at times and with the capacity for verbal play, can't play in most areas of their lives and cannot play except *for* verbally. In group A, A4 described her patient whom she initially described as "creative and playful" but then explained that often her "back will go up and that playful space will shut down." And A2 described her patient whom she explained has a limited capacity for play but did add that it is evolving with therapy. The patient of A9 appears to be the distant outlier. A9

described his patient as “definitely (having) the capacity to play.” He described her as having a “great sense of humor” and very playful in several contexts.

So with regard to the patient of A9, how can every other patient in this protocol be described (on a continuum) as having profound difficulties with a capacity to play and this patient appear to have very little difficulty? And with regard to this patient, she appears to be higher functioning with regard to many of the other attributes. Her attachments were described as “solid,” she exudes a sense of specialness for reasons that appear to be reasonable, she neither retreats nor escapes in therapy nor does she appear to be vigilant – all described as positives in this context. With regard to aggression and provocation, the way provocation was described was in terms of telling people off in order to set and maintain boundaries. Perhaps her therapist is misguided. But judging from his reputation and from what I know about him, I do not think this is the case. So for purposes of argument: how has she fared so well in comparison to other patients? Maybe there just is not enough data to say for sure that this patient really is that much higher functioning or that the others are less high functioning than she is. With a bigger sample, more specific questions over a longer interview protocol, we would have more insight. And maybe it is that the combination of this patient having a particularly strong connection to her father (even at the expense of a relationship with her mother) coupled with having had a mother who was “detached,” but not absent, or violent or psychotic, was enough so that with an already calm, resilient temperament and a host of additional constitutional and environmental factors, this patient is actually better off in myriad ways in terms of her overall functioning.

Summary and Implications for Treatment

> The communicative act of bearing witness to traumatic events not only transforms traumatic memories into narratives that can then be integrated into the survivor's sense of self and view of the world, but it also reintegrates the survivor into a community reestablishing bonds of trust and faith in others.
>
> Aftermath, preface

Every psychoanalyst with whom I've worked on this project (and every clinician with whom I've worked to date) would agree that talk therapy can be helpful to people when they are struggling – struggling to feel better about themselves, in their own skin, with their place in the world. And certainly those who have experienced trauma need to find a way to understand their histories and move forward more comfortably in the world. Daniel Stern talks about the working relationship between patient and therapist as operating in "improvisational mode" where patient and therapist move along in the treatment engaging in many "present moments." Present moments, Stern argues, are "constructed around intentions or wishes and their enactments which trace a dramatic line of tension as it moves toward its goal." (Stern, 1998) And a goal of treatment, Stern argues, is to create what he terms "now moments." Now moments emerge in treatment unexpectedly and present a "hot" present moment – a sort of "moment of truth" which is affectively charged. It's also laden with potential importance of the immediate or long-term future. (Stern, 1998) Experiencing "now moments" in treatment feels great and special, for both the patient and the clinician. Two people have come together and connected in a way that can be very powerful.

A1 provided an eloquent description of how he thinks about the treatment alliance, "We're two people, sitting in a room, doing the best we can, in whatever

imperfect ways are available to us, trying to relate to each other with the goal of building a relationship and helping at least one, but maybe both, in some unspecified way."

And I adore A6's description of how she connects with and works with her patients: "I try to be playful and try to use humor where I can in my work. I think it really builds the, in a lovely way, builds the connection between the two of us. Being playful with the issues, kind of tossing them around, kind of playing with them…it's about, 'just let go' and let's see what comes up – we can play with it…It's about the alliance we have, that we're on the same team. It's to cut through the defense, to make it less adversarial. It's to say, 'let's join together and see if we can come up with what's really going on and in that way be playful."

The relationship between therapist and patient can be extremely intimate. I think to work well, to be meaningful, it probably should be. Daniel Siegel writes, "Intimate relationships involve this circular dance of attuned communication, in which there are alternating movements of engaged alignment and distanced autonomy. At the root of such attunement is the capacity to read the signals (often non-verbal) that indicate the need for engagement or disengagement." (p.70)

Karlen Lyons-Ruth writes about intensely charged, important moments in the treatment experience as "special moments." She describes them as special moments in treatment where the therapist and patient share a unique kind of authentic connection. She and her colleagues believe these moments of meeting constitute a major role in the process of therapeutic change. (Lyons-Ruth) These special moments are comprised of what she and colleagues have termed "implicit relational knowing" and the constructs of "real relationship" and "moments of meeting." "Implicit relational knowing" involves

knowledge of how to be with another – how to play with and how to connect and be with another person. She discusses how it begins to be represented pre-linguistically and continues to develop over time. 'Implicit relational knowing' as a construct raises 'internal object relations' to a more general representational systems conception. (Lyons-Ruth, p. 285) If I understand the concept, "implicit relational knowing," allows for "real relationship" moments to emerge. "Real relationship" is defined as the intersection of the patient's and the therapist's relational knowing." (Lyons-Ruth, p. 285) It is the experience of an authentic connection and experience of being with another person in an authentic, meaningful way. And the co-construction may lead to what Lyons-Ruth, Stern, and their colleagues describe as a "moment of meeting."

A goal for my treatment of patients is to provide a healthy space and holding environment to facilitate growth. "A life of one's own begins in a space of one's own, made safe from external and internal impingements. This safety if first guaranteed by a good-enough caretaker and later, perhaps, by a good-enough analyst. In this space one is free to adventure, explore, and experiment, among other things, with altered states of consciousness." (Bach, 1991, p.119)

Working with such patients, Bach argues that the analyst, "through holding, reenactment, and interpretation, allows for longed-for equilibrium to develop in the analytic system." (Bach, 1991, p.61) It's the object constancy and the holding by the therapist that is critical, I think. And once there is some safety, the therapist may be able to play a bit, thus encouraging the patient to play or to be playful in the treatment, too. It would seem that an important goal for therapy would be for the patient to learn to feel comfortable playing both inside and outside the therapeutic context. And as the research

suggests, an ability to play or to be playful (to be able to step back and to observe oneself, to exercise one's observing ego capacity, to suspend reality and to try on a role or a concept) may be linked to greater health. Even though subjective and subject to qualifiers and caveats, if playfulness may be a measure of health one's ability to play and to be playful might be something clinicians can (or should?) aspire to and look for in all our patients.

There is evidence in the data from this research that with regard to patients with trauma histories, there are important links between one's early experiences with primary caretakers and one's overall health. By identifying certain information in a formal developmental history, like, for example, what a patient's early parenting experiences were, a therapist might also begin to develop a framework for how the patient might think about or function with regard to other attributes like specialness, or what their attachments and object relationships to others might be. The therapist might inquire about vigilance and ways the patient thinks about protecting herself including using the defensive strategy of retreating. And the therapist might listen for ways the patient releases aggression with an ear tuned to listen for provocation or other means of handling anger and aggression. This framework may help to inform the treatment plan for working all patients as well as for working specifically with trauma patients.

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