

**EXPLORING CHILDHOOD POST-TRAUMATIC STRESS DISORDER:  
A CLINICAL CASE STUDY OF A CHILD ABUSE VICTIM**

by

VIRGINIA CROSSLEYSMITH

A clinical case study  
submitted in partial fulfillment  
of the requirements for the degree of

**DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY**

INSTITUTE OF IMAGINAL STUDIES

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This clinical case study has been accepted for the faculty of the  
Institute of Imaginal Studies by:

---

Lisa Herman, Ph.D.  
Clinical Case Study Advisor

---

Melissa Schwartz, Ph.D.  
Academic Dean

---

Anne Coelho, Ph.D.  
Doctoral Project Committee Member

To all the people who have mothered me, including my own mother, Pamela.

In another time's forgotten space  
Your eyes looked from your mother's face  
Wild flowers seed in the sand and stone  
May the four winds blow you safely home

—Robert Hunter  
“Franklin's Tower”

## ABSTRACT

### **EXPLORING CHILDHOOD POST-TRAUMATIC STRESS DISORDER: A CLINICAL CASE STUDY OF A CHILD ABUSE**

by

Virginia Crossleysmith

This Clinical Case Study describes the experience and treatment of a young girl who was abused and neglected by her biological parents. She was removed from their care at age six and adopted at age nine. I explore her experience from the perspective of Post-Traumatic Stress Disorder (PTSD) with particular attention to victims of child maltreatment. I emphasize the inadequacies of the current diagnostic criterion in accounting for the symptoms of children who are victims of abuse.

A discussion of PTSD emanates from the literature relating to the etiology, definition, and treatment of childhood PTSD from a variety of perspectives and approaches including: Biological, Cognitive/Behavioral, Psychodynamic, Sociocultural, and Imaginal. All of the perspectives note that reaction to trauma is normal and adaptive, and that PTSD results when that adaptive response goes awry. The Biological perspective examines physiological reactions emphasizing that children's brains are particularly vulnerable since they are still developing; the Cognitive/Behavioral perspective stresses assimilation or accommodation of trauma-related memories and describes techniques which facilitate this; the Psychodynamic perspective describes unconscious psychological defenses resulting from trauma, and discusses relational-oriented treatment approaches

including play therapy for maltreated children; the Sociocultural perspective emphasizes social adversity increasing the potential for traumatic experiences; and the imaginal approach describes the importance of myths and archetypal imagery in gaining greater understanding of inner processes, and the relationship of those processes to issues of the soul.

The psychotherapy is described in detail noting both the reactions and responses engendered in myself and in my young client, with attention given to the legal and ethical concerns, and treatment outcomes.

I describe my insights into my own and my client's psychological processes and perceptions resulting from the psychotherapy experience, and my interpretations of both. Such insights and interpretations are deepened by a recognition and description of their mythic implications utilizing the myth of Demeter and Persephone in order to amplify the experience and meaning of the therapeutic journey.

Finally I reflect on the significance of the therapeutic journey, and its wider implications, particularly regarding its relationship with the discipline of the imaginal approach to psychology.

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## CHAPTER 1

### INTRODUCTION

#### Clinical Topic

The topic that represents the major area of clinical concern in my case study is *Post-Traumatic Stress Disorder* (PTSD) in children as it manifests in the complicated trauma symptoms resulting from child abuse. In order to describe these more complex symptoms it is necessary to define and describe PTSD as it manifests in adults, either from a single traumatic incident or from an ongoing series of traumatic events. Such descriptions and definitions serve as an underpinning to the description of PTSD in children resulting from the more complex trauma of ongoing child abuse.

PTSD is described in the fourth edition of the *Diagnostic and Statistic Manual of Mental Disorders*, (DSM IV-T-R), as “The development of characteristic symptoms following exposure to an extreme traumatic stressor.”<sup>1</sup> Christine A. Courtois notes that PTSD was first included as a psychiatric diagnosis in the third edition of the DSM in order to describe the symptoms experienced by combat veterans returning from Vietnam and Korea, and that it has since become used to pertain to any individual suffering from the symptoms outlined in the DSM as a result of significant traumatic experience.<sup>2</sup> This study is primarily concerned with complex symptoms resulting from chronic, ongoing trauma as is suffered by victims of child maltreatment. Researchers have attempted to make a distinction between these complex symptoms and PTSD symptoms described in the DSM resulting from either single incident trauma, or trauma which occurs in

adulthood. Courtois discusses this, noting that “the diagnosis of PTSD is not a perfect fit for the reactions experienced by victims of child abuse...where traumatization occurred repeatedly and extensively” since it was originally intended to describe the experience of adult male combat veterans.<sup>3</sup>

Victoria McKeever notes that trauma symptoms have been recognized for centuries, and that the term PTSD is a relatively new name for an already historically established set of symptoms.<sup>4</sup> The recognition of a trauma response in children as a result of maltreatment has a more erratic history. Eliana Gil asserts that the notion of children as the exclusive property of their parents prevented for centuries the recognition that trauma symptoms result from child abuse.<sup>5</sup> Gil writes that during the 1940s some documentation of physical abuse began appearing in hospital settings. She notes that an article of historical importance in this regard was written in 1946 by a radiologist named J. Caffey, who described atypical fractures in the limbs of an infant and suggested that they were the result of child maltreatment.<sup>6</sup> Gil writes that in spite of these observations, it was not until 1962 that C. Henry Kempe coined the phrase *The Battered Child Syndrome* in order to describe the psychological response of maltreated children.<sup>7</sup>

Researchers have noted that there is a discrepancy between the symptoms outlined in the DSM describing PTSD, and the more complex symptoms observed in survivors of child maltreatment. The DSM describes the symptoms of PTSD as inclusive of: “recurrent and intrusive distressing recollections or dreams of the traumatic event, acting or feeling as if the traumatic event were recurring perhaps involving dissociative episodes, persistent avoidance of stimuli associated with the trauma, a diminished responsiveness to the external world, and persistent symptoms of increased arousal.”<sup>8</sup> R.

Scurfield et al. elaborate on this noting that the symptoms of PTSD are marked by their dynamic nature, and can be conceptualized as a set of interacting poles of physical and emotional states, and coping reactions alternating between numbing or dissociative symptoms and intrusive memories or dreams, representing an oscillation between re-experiencing the event and denial of it. Research suggests that such symptoms represent the sufferer's attempt to integrate the traumatic event into their personal history.<sup>9</sup>

The DSM notes that symptoms may manifest differently in children compared with adults: For instance the re-experiencing of a traumatic event may appear in the guise of repetitive play, or "frightening dreams without recognizable content."<sup>10</sup> However, theorists argue that even with this recognition the diagnostic criteria listed in the DSM defining PTSD remains inadequate in describing the disorder of PTSD in children in general, and the more complex symptoms resulting from chronic trauma, such as child maltreatment, in particular. E. Benedek notes that when the term PTSD was initially coined there was some controversy regarding whether or not children could receive the diagnosis at all since a child's reaction to trauma is often very different from an adult's.<sup>11</sup> Kenneth Spitalny contends that there remains concern that children will not meet the diagnostic criteria necessary in order to be diagnosed with a psychiatric disorder even though they have significant psychopathology, and a lack of diagnosis may result in inadequate treatment.<sup>12</sup> An example of this concern is demonstrated in a 1985 research study by N. Garnezy and M. Rutter involving children. The researchers concluded that "children's reactions to trauma were not as serious as those developed by adults," therefore their reactions to trauma did not warrant inclusion in the diagnostic category for PTSD.<sup>13</sup>

A research study by K. A. Dodge et al. quantified social processing patterns in abused children.<sup>14</sup> Dodge et al. reported that their findings resulted in the identification of specific symptoms suffered by victims of the complex trauma of child abuse, and indicated that abused children develop unique cognitive patterns including the following: a lack of awareness of non hostile social cues, a hypervigilance to all social cues, and a greater tendency to attribute hostile intent to other children's behaviors. David Pelcovitz et al. suggested that symptoms related to complex PTSD involve symptoms described earlier and itemized in the DSM criteria in addition to problems with self regulation, self definition, interpersonal functioning, and adaptive style.<sup>15</sup> Pelcovitz et al. explored the experience of 234 victims of childhood abuse and identified seven clusters of diagnostic criteria differentiating PTSD as described in the DSM from complex PTSD. These clusters included: impairment of affect regulation; impulse dyscontrol and self destructive behavior; altered states of consciousness with amnesia and dissociative symptoms; alterations in perception of the perpetrator; alterations in self perceptions including intense feelings of guilt and shame; distorted relations to others with isolation and distrust; somatization; and alterations in one's system of meanings. Pelcovitz et al. collaborated in a field trial between 1991 and 1992, the purpose of which was to investigate alternative versions of the PTSD stressor criterion in order to describe complex PTSD, and to argue for the development of psychiatric nomenclature designed to account for the complex constellation of symptoms resulting from the "multiple dynamics, and associated adaptations present in situations of interpersonal exploitation" as experienced by maltreated children.<sup>16</sup>

Veronica Pappagallo, Raul Silva, and Veronica Rojas also emphasize the need to provide a descriptive term to differentiate between PTSD as defined by the DSM, and more complex symptoms resulting from child abuse.<sup>17</sup> They cite the work of J.L. Herman who proposed a new diagnostic category to be included in upcoming editions of the DSM: “Disorders of Extreme Stress Not Otherwise Specified.”<sup>18</sup> Even taking all of these factors into account, some researchers feel the necessity for a set of diagnostic criteria for children under the age of four which is more sensitive to their developmental abilities. M.S. Scheeringa and C.H. Zeanah suggest that such criteria include a recognition of compulsive repetitive traumatic play, trauma re-enactment within play, constriction of play or imagination, social withdrawal, and a restricted range of affect.<sup>19</sup>

Regarding the prevalence of the disorder in children, Vilma Gabbay et al. note that there is a paucity of studies examining the lifetime prevalence of PTSD amongst children.<sup>20</sup> In order to illustrate this point Gabbay et al. cite a 1998 research study by S.P. Cuffe et al. which examined the prevalence of PTSD amongst 490 older adolescents aged between 16 and 22, and estimated the lifetime prevalence of PTSD in adolescents at only two percent.<sup>21</sup> Gabbay et al. cite a second and contradictory study by N. Breslau et al. which involved a random sample of 1,007 young adults, and estimated the lifetime prevalence of PTSD in children to be 9.2 percent. Statistics gathered by D. G. Kilpatrick and K. J. Ruggerio derived from a 2003 survey of adolescents estimate the prevalence of PTSD in the general population of adolescents at 6.3 percent for girls, and 3.7 percent for boys.<sup>22</sup> While such discrepancies in statistics may be due to the underreporting, and misdiagnosing of PTSD in children, as well as inconsistent definitions of what constitutes child abuse, it is evident that child maltreatment is widespread. Statistics from the U.S.

Department of Health and Human Services gathered in 1999 estimate that based on data from 44 states, 984,000 children experienced some form of maltreatment.<sup>23</sup> Statistics collected by S.V. McLeer et al. as a result of their quantitative research of PTSD in sexually abused children suggest that more than 50 percent of sexually abused children meet partial or full criteria for PTSD.<sup>24</sup>

Recognizing and treating the symptoms of PTSD resulting from child abuse is crucial since they profoundly affect the quality of the lives of the victims. For example, Kiara R. Cromer and Natalie Sachs-Ericsson note that their research examining the comorbidity rates of adults with medical problems and a history of childhood abuse suggests that such individuals suffer a higher rate of medical problems than the general population.<sup>25</sup> In addition, studies have shown that individuals with a history of childhood abuse have difficulties with interpersonal relationships and social issues, and tend to be overrepresented in the criminal justice system. Carsten Spitzer et al. explore this issue, they cite statistics gathered by V. G. Carrion and H. Steiner whose demographic surveys involving juvenile hall inmates indicate that 97 percent of the adolescents incarcerated had a history of childhood trauma.<sup>26</sup> Spitzer et al. also cite research by A. Dixon et al. who gathered demographic information from incarcerated adolescents, and asserted that their statistics showed that 70 percent of female juvenile offenders had been sexually abused.<sup>27</sup> A demographic study involving adult male prison inmates by K. Fondacaro et al., and cited by Spitzer, suggested that 40 percent of adult male prison inmates had a history of childhood sexual abuse.<sup>28</sup> Spitzer and her colleagues' own research involved a sample of 32 adult forensic patients. They noted that a substantial proportion of their



sample had been severely victimized in childhood, and nearly half met the diagnostic criterion for PTSD with additional symptoms related to complex PTSD.<sup>29</sup>

Adult research has shown that not all individuals who experience a significant trauma develop PTSD. A.C. McFarlane compiled statistics from several studies examining this phenomenon as it relates to adults.<sup>30</sup> McFarlane reported that estimates typically ranged from five percent to 35 percent in terms of the number of individuals exposed to a traumatic stressor who go on to develop PTSD, and few estimates exceeded 50 percent. It has been suggested that the reason for this is that in order for traumatic experience to result in PTSD there must be predisposing factors. This is of particular concern to victims of child abuse suffering from the result of complex trauma since studies have indicated that a history of prior adversity, including childhood maltreatment, is a predisposing factor to an ongoing vulnerability to PTSD or other psychopathology. Illustrating this point a study by E.J. Ozer and colleagues utilized a meta-analysis of research examining predictors of PTSD in adults. Ozer et al. asserted that their analysis indicated that a history of childhood abuse leaves a legacy of a lifetime predisposition to developing PTSD in the face of further trauma, as well as other psychopathology.<sup>31</sup>

There has been a connection drawn between childhood abuse, faulty attachment to early caregivers, and an ongoing vulnerability to developing PTSD. Attachment theory represents the work of Sir John Bowlby.<sup>32</sup> Bowlby's theory, developed during the 1940s and 1950s, argues that ties formed between children and their parents, particularly their mothers, crucially affect personality development and traits related to self confidence. In his discussion of the relationship between attachment theory and trauma symptoms related to child abuse Paul Verhaeghe draws the conclusion from his review of the

literature on this point that trauma in itself is not sufficient for the subsequent development of PTSD, and that child abuse increases the risk for developing a wide range of psychological symptoms, including PTSD.<sup>33</sup> Verhaeghe writes that it is unclear why child maltreatment increases ongoing vulnerability, and hypothesizes that the development of PTSD is determined by more factors than the trauma itself or even a history of adversity, and includes the phenomenon that child abuse victims fail to develop adequate mediating psychological resilience to trauma. Verhaegue suggests that this lack of resilience is the result of faulty attachment to early caregivers. Heller Landecker asserts that families with a history of sexual and physical abuse tend to be neglectful as well, thus contributing to an infant's faulty attachment to early caregivers.<sup>34</sup> Marylene Cloitre agrees, hypothesizing that childhood abuse by primary caregivers represents an interruption in attachment which removes a potential mediating factor for children in the development of PTSD following a trauma.<sup>35</sup>

The following chapter will further explore the clinical topic of PTSD with emphasis on the more complex symptoms which arise as a result of child maltreatment from a biological, cognitive behavioral, psychodynamic, and sociocultural perspective, and from the approach of Imaginal Psychology. This chapter will include discussions of the issues mentioned above from these different perspectives including the following: the etiology of the disorder as it results from child maltreatment, predisposing vulnerabilities, ongoing risk of future psychopathology or revictimization, and the overlap of the disorder with faulty attachment to primary caregivers.

All of these issues are relevant to the client whose experience I will describe in this Clinical Case Study. The client is "Sally" (pseudonym), an 11-year-old, sixth-grade,

Caucasian female, who was a victim of ongoing and chronic maltreatment by her primary caregivers who were her biological parents. As a result of her history, Sally experienced the more complex trauma likely to result in enduring psychopathology. Increasing her risk factor for the development of profound symptoms was the fact that her abuse occurred from the ages of zero to six. Since Sally's abuse was perpetuated by her primary caregivers, there was the possibility of inadequate attachment to those caregivers.

Given Sally's known history, it was my opinion that trauma could be assumed to be the central organizing principle in Sally's interactions with her world. A psychological evaluation administered to Sally in 2005 noted that she suffered from many of the symptoms associated with childhood PTSD.<sup>36</sup> It was my observation that Sally suffered from symptoms outlined in the diagnostic criteria included in the DSM. For example, she suffered from recurrent nightmares and dissociative symptoms, and had problems with peer relationships. She experienced considerable anxiety, had a heightened startle response, and was fearful of many things including dark places and being left alone; she had day and night time enuresis for which there was no medical explanation; and she hoarded and gorged food and was uneasy if there was no food source available. It was for those reasons that I gave Sally the diagnosis of PTSD, and chose to explore her experience through the lens of complex PTSD resulting from child abuse.

### **Personal Exploration of the Subject/Topic Choice**

My choice of this clinical topic was based in part on the fact that working with children who have been the victims of maltreatment has constituted a major part of my professional experience. I began my professional career in this regard as a *Court*

*Appointed Special Advocate (CASA)*, which is a volunteer position advocating for children in foster care who have become dependents of the court because of abuse or neglect. The function of a CASA is to assure that the opinions and needs of these children are included in decisions made on their behalf by the court. Following that experience, I have worked with foster children in some regard ever since, both as a psychotherapist and as a social worker.

As previously mentioned, victims of complex trauma often have multiple, severe symptoms. Such symptoms in children may be misdiagnosed or labeled as difficult to manage behaviors, and often appear to those witnessing them as disturbing, or dangerous. For instance, the symptom described so neatly as “affect regulation problems,” can manifest in children as screaming tantrums, or disturbing degrees of aggression to other children or animals. Dissociative symptoms resulting from complex trauma may be perceived as a child seeming distracted or dreamy, or may manifest in substance abuse or a child sexually molesting another child. Some examples of complex trauma symptoms which I witnessed during my years working in Child Protective Services included: an eight-year-old boy who was caught attempting oral sex with an eight-month-old baby, a seven-year-old girl who had screaming tantrums which lasted for hours if she could not get her socks to be exactly symmetrical, a six-year-old boy who systematically killed six kittens and reported that he could not remember doing it, a 10-year-old boy who grew up fending for himself as a result of chronically substance abusing parents and repeatedly wandered off outside to find dog feces to eat, and a six-year-old boy whose nighttime sleepwalking episodes would take him into the kitchen on many nights where he would turn on all the burners of the stove. I have many more equally disturbing examples. Even

when such behaviors are recognized as trauma symptoms, treatment may be inconsistent in the confusion of foster care placements and legal proceedings. Without adequate treatment, symptoms have a tendency to endure into adulthood, creating a lifetime of ongoing problems.

Also informing my choice of clinical topic and my reasons for being in this profession in the first place is my own personal experience growing up. I suffered the loss of my mother first to mental illness, then to alcoholism, and finally to death as a result of her drinking. I have always felt that during the first 10 years of my life I was connected in positive ways to my mother. When she was doing well, my mother was kind, warm, and funny; however, she was always prone to unexplained rages, no doubt the first emergings of her mental illness. After I turned 11, these rages became more frequent and gradually I withdrew from her feeling that I lost her long before she died.

Through teenage years and into early adulthood my peer relationships took precedence over family connections. Later, after two failed marriages, I felt myself drawn steadily and strongly into the world of psychotherapy with an emphasis on the treatment of children, driven no doubt by an unconscious motivation to find language and explanations for my own experience. A heightened sense of responsibility resulting in a drive for academic achievement propelled me through the next several years, and I continued to stave off the real sense of grief for my mother hidden behind the force of my vocation. My mother died when I was 39; at the time I had not seen her for seven years. While writing this Clinical Case Study and during my therapy journey with Sally, my awareness of my own underlying grief for this lost time and for my mother has become more apparent. It has manifested in moments of yearning for her, and remembering who

she was aside from her mental illness and alcoholism. My grief is made more poignant by this recognition of who she could have been if she did not have the twin demons of madness and substance abuse to battle. Such recognition continues to keep me open to the experiences of others and inform my therapy practice and professional choices.

### **Framework of the Treatment**

I worked with Sally as a volunteer psychotherapist for a non-profit organization dedicated to providing pro bono psychotherapy to children who have been in foster care, namely the Children's Therapy Project. I provided these services in my private practice office under the auspices of my clinical social worker license. My private practice office is situated in a suite of offices occupied by psychotherapists, one of whom was the supervisor of this case study. My office is a comfortable and cozily furnished room with a sand tray, art supplies, and other toys and games. I found that the consistency of meeting with Sally in the same office each week was helpful in providing this highly traumatized client with an ongoing sense of security and predictability.

The Children's Therapy Project works in conjunction with the Department of Social Services which refers children involved in the foster care system who are in need of psychotherapy. Sally was referred to the Children's Therapy Project by the Department of Social Services, and the Children's Therapy Project referred Sally to me. At the time of the referral I was given a brief description of Sally's history and told that she had a history of abuse and neglect, and was living in a foster/adoption home with her sister, "May" (pseudonym), who is approximately three years younger than her. In addition, I was given the names and contact information of the various social workers and

a behavior specialist who had worked with Sally, and was able to contact those individuals for collateral information. Sally and May were adopted during the course of our treatment. As I will describe later, May was eventually referred for treatment in addition to Sally, but due to difficulties in finding therapists willing to provide pro bono work, as well as the fact that she was younger, Sally was referred first.

The model that the Children's Therapy Project uses provides a two hour, bi-weekly consultation group consisting of up to three providers, and two consultants. The group that I attended was run by my supervisor, who is the local director of the project, and another clinician, both of whom are licensed clinical psychologists. The Children's Therapy Project uses a psychodynamic theoretical orientation, as does my clinical supervisor, although providers and supervisors are supportive of other approaches and knowledgeable about other orientations. The group approach of the consultation group was invaluable in providing insights and encouraging objectivity during the psychotherapeutic process. Both discussions of my own case, and involvement in discussions of other cases enriched my work exponentially, and I feel privileged to have had this opportunity.

I began working with Sally in October 2005. We largely maintained a schedule of 50-minute sessions once a week. In general, and with one notable exception, we had no contact in between sessions. I made infrequent telephone contact with Sally's adoptive mother, "Lucy" (pseudonym), in order to check on Sally's progress. I did not engage Lucy at the time of Sally's sessions in an effort to preserve the time as well as to avoid Sally perceiving the sessions as a time when Lucy could tell me what Sally was doing wrong so that I could correct her behavior. The one exception to our between-

session-contacts was when I attended Sally and May's adoption proceeding. Although this could have been perceived as a breach in our therapeutic container, or perhaps a tacit approval of Sally's adoption precluding her from voicing any future ambivalent feelings about her adoption to me, I felt, and my consultation group agreed, that the benefit of attending the proceeding was that Sally would have a witness to both her pre-adopted self and her post-adopted self, and would provide continuity in a life that had little consistency to date. With the psychodynamic orientation of the Children's Therapy Project in mind, I utilized a variety of approaches including art therapy, sand tray, and journal writing. I also involved supportive counseling, parent support, and psycho-education for Sally's adoptive mother.

### **Confidentiality and Ethical Concerns**

In order to protect Sally's identity in this Clinical Case Study, I have used pseudonyms for Sally and all other individuals mentioned in relation to her. In addition, I have not been specific about where Sally lived or where she was from. Since Sally was a legally adopted minor, Lucy was the holder of the privilege of confidentiality and the person responsible for giving consent for Sally's treatment, as well as for giving permission to be the subject of this Clinical Case Study. Lucy was supportive and cooperative regarding these issues. Not only was Lucy committed to doing whatever was necessary to provide care for Sally and May, she was supportive of any research which could result in deepening an understanding of trauma response, particularly as it relates to victims of child abuse. In general, Lucy did not need to know the details of the treatment and was forthcoming with information about Sally's behaviors and emotional states.



May began treatment in late 2006, approximately a year after Sally had been in treatment with me. Prior to that Lucy had reported to me that May was having increasingly intense nightmares and screaming out in the middle of the night. Lucy's growing concern prompted me to advocate strongly for the Children's Therapy Project to provide May with a therapist. Lucy was greatly relieved, and was diligent in maintaining both girls' involvement in therapy. Lucy gave me permission to be in communication with May's therapist, and my communications with her were most helpful. I communicated with May's therapist by phone approximately once every eight to 12 weeks, and compared concerns and treatment approaches. In addition, we used our contacts to ensure consistency with the advice and guidance that we gave to Lucy. The most prevalent ethical issue was that we shared the same office, but on different days. We both had concerns about how our treatment might be affected by this. We each assured our respective clients that their artwork and writing would be kept in its own private, locked drawer unless they expressed a desire to take it home. As our mutual therapy journeys unfolded, this issue has not proved to be an impediment to treatment.

### **Client History and Life Circumstances**

Sally was nine years old when I first met her in October 2005. Prior to my work with her, she had not had any psychotherapeutic treatment. During treatment Sally and May lived with Lucy, her two cats, and amiable golden retriever dog, in a comfortable three bedroom home in a moderate sized, Northern California city. Lucy adopted Sally and May in August 2006. Lucy was a middle-class, single, working mother, who earned enough in her position as a computer soft-ware analyst, combined with some

supplemental income provided by the state to aid parents who have adopted children out of the foster care system, in order to adequately support herself and her young family.

Sally was removed from her biological mother at age six due to neglect, and allegations of physical, sexual, and emotional abuse. May was removed at the same time. According to substantiated allegations by Child Protective Services (CPS), in addition to the abuse and neglect Sally witnessed domestic violence, and the sexual abuse of May by their biological father. Given the circumstances, it is reasonable to assume that Sally was sexually abused also. Sally's birth history is unknown, as is her developmental history during her first six years of life. According to Sally's Department of Social Services Social Worker, it was clear from various reports to CPS in various Northern California counties that Sally's family moved around a great deal. Also according to CPS reports, Sally had an older sister who was removed from the family prior to Sally and May being removed, apparently because Sally's mother was offering her to acquaintances for sexual favors in order to receive drugs. It is not known how much Sally knew about her older sister's experience, and she has never mentioned it.

Sally's parents were polysubstance abusers, using alcohol, methamphetamine, and other drugs. It is unclear whether or not Sally was born positive to any substance, or whether Sally's mother used drugs during her pregnancy. Sally has a blood disease called *spherocytosis*, which is a hereditary, chronic illness characterized by abnormal red blood cell membranes, an enlarged spleen, and jaundice.<sup>37</sup> As a result of this condition she had to have her spleen removed at age five. This surgery compromised her immune system's ability to fight off infections, and she will have to take a daily dose of antibiotics for the rest of her life. According to Lucy, Sally did not mind taking the medication, and there

were no further adverse consequences relating to the illness or her surgery. Although details of Sally's surgery were unavailable, given her age at the time and what is known about her caregivers, it can be assumed that this experience was traumatic for her.

Sally and May were placed in a number of foster homes before they were moved to Lucy's home in August, 2004. In 2005, prior to her adoption, Sally and her sister received a psychological evaluation.<sup>37</sup> The evaluation noted Sally's history of maltreatment suggesting that Sally's ongoing anxiety, difficulties in peer relationships, hoarding and gorging of food, and poor affect regulation were responses to trauma. As a result of their findings, the evaluators recommended psychotherapy. In addition, they suggested a medication evaluation in the future if her anxiety did not diminish. An example of Sally's maltreatment is mentioned in this report which notes that she was found at about age five, waiting at a bus stop filthy, and covered in bruises and welts, the result of physical abuse from her father. Testing by the evaluators found Sally's IQ to be in the low average range. The evaluators opined that Sally's low scores were largely the result of neglect, inconsistent school experience, and lack of exposure to enriching environments. It was recommended that Sally's academic abilities be retested in approximately two years after she had spent time in a stable and enriching environment.

Sally remained in her adoptive home for the length of our treatment. Sally had an Individualized Education Plan at her school, and was receiving help in reading and writing. Sally began taking SSRI antidepressant medication approximately one and half years following the start of our treatment at the advice of a psychiatrist whom she had been seeing intermittently since being in foster care. Lucy reported that the medication helped with her tantrums and mood swings at home although I did not notice any change

during our sessions. I had two very brief consultations with this psychiatrist. The first consultation was immediately prior to Sally beginning the medication. At that time the psychiatrist reported that he understood Sally's early history, and that it was his opinion that medication would help Sally to regulate her emotions, particularly her anger as it manifested in tantrums. The second was approximately six months later, and we both agreed that the medication had indeed helped in the way that he had hoped.

### **Progression of the Treatment**

I began working with Sally in October 2005 and continued to work with her throughout the writing of this Clinical Case Study. Sally was originally brought to treatment by Lucy at the recommendation of her Social Services social worker. Lucy related to me that she hoped that psychotherapy would assist in alleviating her anxiety and nightmares. Lucy was also concerned about Sally's peer relationships since her difficulties with anger management often resulted in peer conflicts; although Sally made friends easily she had difficulty keeping them. Lucy reported that Sally's conflicts were often the result of her apparent jealousy, and possessiveness of her peers. For instance, she disliked it if one of her friends was also friends with someone else. Lucy reported that she hoped that in addition to these issues, psychotherapy would address Sally's teasing of animals. She said that although it was evident that Sally loved animals, she was caught on several occasions hitting the neighbors' dogs with sticks, and kicking her own cats. Lucy said that Sally did not offer any reason for such behavior and seemed to have a "dead-look" while she was doing it. Lucy felt, and I concurred, that this behavior was related to her past trauma, and as such may be responsive to psychotherapy.

Sally was an enthusiastic participant in our sessions, she willingly engaged in art making, journal writing, sand play, and other activities. It was clear that she looked forward to our weekly hour together, and seemed grateful to have an opportunity to express herself freely. For the first year of our time together, Sally spent the greater proportion of our hour together working in the sand-tray building scenes with some repetitive themes including: the pairing of mother and child animals next to a food source, and a treasure of some sort guarded by fierce animals. Gradually her emphasis moved towards story writing and journal writing. Her journals generally consisted of a record of her activities, and a way to name her new extended relations: for instance, she would name her adoptive cousins and how they were related to her. Sally tended to express her experiences before living with Lucy in metaphorical ways contained in her sand-trays and art. Throughout it was evident that the quality and consistency of my relationship with Sally remained a crucial ingredient of our therapeutic journey, and there were several instances of her testing the reliability of our relationship.

### **Learnings**

As a result of the writing of this Clinical Case Study my awareness has grown regarding the depth and destructive potential of maltreatment on a developing child, in particular abuse suffered at the hands of a primary caregiver. Relationships with early caregivers are fundamental to personality development, and interruptions in such relationships have the potential to stunt developmental growth. With this in mind, as I moved through my therapeutic journey with Sally, I was ever more aware that some of the deep healing from her early trauma must occur within our therapeutic relationship and

result from Sally finding that relationship to be consistent and trustworthy, unlike her earlier experiences. I observed that as Sally came to trust our relationship and the therapeutic process, she was able to share her inner world with me. Within that sharing I found the connection between Sally and I to be centered in our mutual losses, and the points at which our shared histories connected. Conceptualizing the qualities of a mother/child relationship was all important in understanding these connections.

### **Personal and Professional Challenges**

Sally's history of abuse and neglect by her parents was particularly horrific. She herself was such a curious and spirited child that it was painful to reflect on how cruelly her individuality was suppressed during her early years. Given that poignant juxtaposition it was a challenge for me not to simply tacitly pretend that her early experience did not happen and encourage her to do the same; in other words to ally myself with just one part of her experience to the neglect of the other. On the other hand, in my efforts to create a forum for Sally to express her experience in her own way and at her own pace, I had to remain aware of any unconscious agenda of my own wanting to push her faster than she was ready to go in order to unearth and neutralize her past trauma. In general, my therapy journey with Sally has been such a profound experience that it has challenged me considerably to find words which adequately describe its magical nature.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **Introduction and Overview**

It is generally agreed that from whatever perspective PTSD is regarded there are debilitating symptoms which may result from an individual's exposure to significant trauma. A physiological and psychological reaction to trauma is considered to be a normal, healthy response with the purpose of alerting an organism to potential danger and increasing its chances for survival. However, some individuals develop enduring symptoms which do not disappear after the cessation of the trauma. Considering trauma to be a psychophysical experience is particularly significant for children whose brains are still developing. Children who are victims of maltreatment and suffer chronic trauma are especially at risk for serious and persistent trauma symptoms. The following chapter explores the nature, etiology, and treatment of symptoms resulting from trauma from a variety of perspectives, with particular attention to victims of child abuse.

Psychological symptoms resulting from PTSD have a biological and physiological underpinning. According to Babette Rothschild, a normal response to trauma involves specific physiological reactions and there are physiological consequences if the response becomes maladaptive, including possible changes in brain morphology.<sup>1</sup> Raul Silva and Lena Kessler note that research has focused on examining which specific neurological functions go awry during the process of an adaptive response

to trauma becoming maladaptive. Studies have suggested that it is the function of cortisol and its effects on the amygdala which are central in this process.<sup>2</sup>

Research by McKeever and Huff has suggested that the presentation of trauma symptoms in children differs from symptoms in adults largely as a result of a child's developmental level, and that the current diagnostic criterion included in the DSM is inadequate in describing these symptoms.<sup>3</sup> In addition, Spitalney notes that trauma symptoms in children resulting from child maltreatment may present differently than trauma symptoms in adults, or trauma symptoms in children resulting from single incident trauma, and the current definition of PTSD does not account for this.<sup>4</sup> Since PTSD was a disorder first identified in combat veterans and there was controversy regarding how it manifested in children, much of the literature flows from an original understanding of the disorder's manifestation in adults.<sup>5</sup> Verhague's study indicates that the quality of the relationship to early caregivers may constitute a vulnerability to a later development of PTSD.<sup>6</sup> Cloitre et al. write that an individual's positive relationship with a caregiver who feels secure provides an ongoing resiliency to that individual in the face of further trauma.<sup>7</sup> In contrast, a poor relationship with such a caregiver resulting in interrupted attachment increases the potential of that individual to develop psychopathology. Landecker asserts that child abuse at the hands of a primary caregiver can both represent an interruption in attachment as well as constitute chronic trauma, thus providing the circumstances for profound symptoms to result.<sup>8</sup> Benedeck contends that successful treatment for children with PTSD must take into account a child's developmental level and the etiology of the disorder.<sup>9</sup> Various treatment approaches are described in the following sections.



## Biological Perspective on Post-Traumatic Stress Disorder

Researchers have noted that there is a normal and adaptive response to trauma which involves body functions going into a state of hyperarousal. Studies have indicated that this response becomes problematic when the hyperarousal is sustained over time because of chronic trauma. Babette Rothschild relates that the normal physiological response to trauma is commonly referred to as *the fight or flight reaction*.<sup>10</sup> McKeever notes that this reaction to trauma is adaptive by aiding an organism's ability to escape danger.<sup>12</sup> However, she cautions that chronic hyperarousal resulting from ongoing trauma is problematic, particularly for children who are especially susceptible to neurological change since there are critical periods in brain development during childhood.

Rothschild provides a description of the neurobiological and physiological events which occur during a normal response to trauma.<sup>13</sup> She states that the mammalian trauma response system is mediated by the limbic system, located in the center of the brain, which regulates survival responses and emotions. Within the limbic system there are two related areas central to memory storage; the hippocampus and the amygdala. In the case of danger the amygdala sends an alarm to the hypothalamus which stimulates the Sympathetic Nervous System (SNS) while simultaneously emitting corticotropin releasing hormones. The SNS stimulates the adrenal glands to release epinephrine and norepinephrine which prepares the body for flight or fight by increasing respiration and heart rate, and by sending blood away from the skin and into the muscles for quick movement. At the same time, the corticotropin releasing hormones activate the pituitary gland which releases adrenocortio-tropic hormones; these in turn activate the adrenal

glands into releasing hydrocortizone and cortisol. The purpose of the cortisol is to halt the alarm reaction after the danger is over thus returning the body to pre-trauma stasis.

Rothschild states that the functioning of these systems together is referred to as the Hypothalamic-Pituitary-Adrenal Axis, or HPA axis. Bessel Van der Kolk elaborates on the function of the hippocampus and the amygdala within the HPA axis. Van der Kolk hypothesizes that during trauma the amygdala aids in the processing of emotional memories involving, for instance, terror and horror.<sup>13</sup> Van der Kolk opines that the hippocampus aids in giving time and space context within an event so that such memories can be incorporated into existing experience.

R. Yehuda, A.C. McFarlane, and A.Y. Shalev describe the role of cortisol within the HPA axis.<sup>14</sup> They report that the cortisol's purpose is to stem the cascade of trauma reactions by inhibiting activities at the hypothalamus and pituitary and other biological reactions set in motion by the HPA axis, especially those of the SNS. Yehuda, McFarlane, and Shalev assert that it is the mediating function of the cortisol which stops a normal stress reaction from becoming maladaptive by preventing the body from remaining in a state of hyperarousal longer than necessary. Raul Silva considers how the adaptive response to trauma becomes problematic, and opines that it is related to the mediating function of the cortisol system going awry resulting in the body remaining in a state of hyperarousal.<sup>15</sup> In order to understand which processes malfunction when cortisol production becomes problematic, it is necessary to understand in more depth what cortisol does. C. Heim et al. suggest that the way in which cortisol performs is by regulating such physiological stress reactions as increased heart rate, increased locomotive activity, heightened startle response, over-sensitivity to psychosocial

situations, pervasive feelings of fear, the regulation of arousal, vigilance, and behavioral inhibition.<sup>16</sup> Heim et al. write that an over-production of cortisol produces disruptions in these reactions.

James W. Kalat notes that continuous cortisol production resulting in more cortisol than is necessary increases the vulnerability of neurons in the hippocampus.<sup>17</sup> He posits that this may create a predisposition to develop PTSD. Kalat proposes that, although PTSD reactions have been associated with high levels of cortisol production, paradoxically individuals who have ongoing PTSD symptoms tend to have low levels of cortisol, and low levels of cortisol production by individuals post trauma has been suggested to be a factor relating to a vulnerability to PTSD.<sup>18</sup> Yehuda and McFarlane contend that their study supports this finding, noting that a predisposition to developing PTSD is associated with decreased levels of cortisol.<sup>19</sup> Yehuda and McFarlane suggest that this is the result of an increased sensitivity in the HPA axis which becomes damaged as a result of unregulated production of cortisol.

Providing evidence in support of the hypothesis that prior experience of trauma results in decreased cortisol levels thus contributing to a predisposition for the development of PTSD, H. Resnick et al. examined adult female rape victims and found that there were lower cortisol levels in the acute phase after rape in women who had been assaulted previously when compared with women who had not been assaulted.<sup>20</sup> In addition, the previously assaulted women were three times more likely to develop PTSD in the face of the current assault than those who had never been assaulted. Resnick et al. suggest that this finding may indicate that prior trauma is associated with attenuated HPA axis process which affects cortisol production. Supporting this notion, a study by Yehuda

et al. examined cortisol levels in holocaust survivors and reported that the lower cortisol levels found in PTSD sufferers represented a preexisting vulnerability associated with developing PTSD.<sup>21</sup> Yehuda et al. suggest that prior trauma is associated with attenuated HPA axis processes and may represent a risk factor for PTSD development.

There is evidence that cortisol dysregulation affects hippocampal function.

Rothschild asserts that the purpose of the hippocampus in trauma reactions is to assist the organism in storing the experience appropriately within contextual memory, thus giving a sense of time and space to traumatic events.<sup>22</sup> She suggests that hippocampal dysfunction plays a part in the development of PTSD, and that prolonged elevations in cortisol levels contribute to such dysfunction. McKeever concurs, citing a study by Gurvits et al. who hypothesize that chronic exposure to trauma has been associated with structural changes in specific areas of the brain, including the hippocampus.<sup>23</sup> McKeever writes that animal research by C.S. Wooley et al. indicates that prolonged exposures to stress induced glucocorticoids alters hippocampal neuronal morphology.<sup>24</sup> McKeever also notes a study by J.D. Bremner et al. who found greater degrees of hippocampal atrophy among Vietnam veterans diagnosed with PTSD when compared to a control group.<sup>25</sup> Rothschild posits that some individuals may be born with smaller hippocampi than others, predisposing them to develop PTSD.<sup>26</sup>

Regarding how this relates to victims of child abuse, C. Heim et al., as a result of their quantitative research on the etiology of PTSD suggest that alterations in the stress response neurobiological systems indicates a link between stressful experiences, such as child abuse, and a later predisposition to develop PTSD.<sup>27</sup> Many important structural changes in the brain take place in childhood and early adulthood. T.R. Jernigan and E.R.

Sowell write that the myelination of the brain increases significantly during the period of six months to three years of age and continues into the 20s.<sup>28</sup> P.S. Goldman asserts that the prefrontal cortex develops last and this development continues into the 20s.<sup>29</sup> D. Cichetti and D. Tucker contend that differentiation in the brain, including synaptic pruning, is sensitive to stress and stimulation from the environment.<sup>30</sup> Sharon C. Kowalik suggests that as a result of these developing structures, childhood trauma has the capacity to lead to faulty brain development and the failure of important pathways in the brain to develop, which explains why victims of child abuse have a predisposition to develop psychopathology and a lifetime of increased vulnerability to PTSD.<sup>31</sup> M.D. DeBellis et al. examined magnetic resonance images of 44 children and adolescents with PTSD and compared them to 61 healthy controls taking into account differences in birth history, and other comorbid diagnoses.<sup>32</sup> They found that the maltreated children had small cerebral and prefrontal cortex volumes when they controlled for age, height, weight, and gender. The children also had small cerebral, prefrontal, and right and left amygdala gray matter. The right and left amygdala total volumes were decreased, and the left and right temporal lobes and the corpus callosum in particular regions were also smaller. This finding was repeated in a 2001 study by Katherine A. Richert et al. who examined the brains of 24 children between the ages of seven and 14 diagnosed with PTSD.<sup>33</sup> Richert et al. asserted that children with PTSD had a decreased volume of gray matter which correlated with increased functional impairment, and that the abused children appeared to have smaller total brain volumes, suggesting that exposure to traumatic events in children has the potential to result in problems and deficits, many of which may be permanent.

There is some controversy amongst researchers regarding the degree to which childhood stress can affect hippocampal volume and/or function. M.B. Stein et al. measured hippocampal volume in women abused as children and found it to be significantly reduced in adult women who were victims of childhood physical abuse when compared with women who did not have such a history.<sup>34</sup> F.W. Putnam and P.K. Trickett suggested that their quantitative research involving girls with a history of abuse established the presence of significant levels of HPA dysregulation and decreased hippocampal volume.<sup>35</sup> In contradiction to these findings, other studies did not note decreased hippocampal volume in abused children. Research by DeBellis et al. indicated that hippocampal volume in children did not decrease as it appeared to in adults.<sup>36</sup> This finding held true in a follow up, longitudinal study by DeBellis et al. involving nine prepubertal maltreated children. The researchers measured hippocampal volumes at baseline, and two years later.<sup>37</sup> The authors suggested that this may be because the hippocampus in children is still developing, or that it takes longer for changes in the hippocampus to become evident.

In terms of pharmacological therapy for PTSD sufferers, Lori L. Davis et al write that their review of current literature and research indicates that Selective Serotonin Reuptake Inhibitor medications (SSRIs), are considered the first-line, short-term pharmacological treatment of preference for PTSD.<sup>38</sup> SSRIs work by increasing the available supply of serotonin in the brain, a neurotransmitter believed to affect mood. Davis et al. reviewed three randomized, double-blind, placebo-controlled studies researching the effectiveness of SSRI medications. The first, by P. D. Lonnberg et al. entailed a 24 week flexible dose, double blind study, comparing the SSRI Sertraline with

a placebo.<sup>39</sup> The study involved 252 adult patients with PTSD, all of whom had been successfully treated with Sertraline. Approximately half of the participants were randomly selected and treated with placebos and monitored for relapse. The results indicated that Sertraline is an effective long term treatment for PTSD. A second study by E. Vermetten et al. involved 23 adult PTSD sufferers and examined the efficacy of Paroxetine, specifically in regard to memory and hippocampal volume.<sup>40</sup> Vermetten et al. reported that their findings suggested that treatment with Paroxetine was successful. The third study was conducted by F. Martenyi et al., and examined the effectiveness of Fluoxetine versus a placebo in the prevention of a relapse of PTSD symptoms in adults.<sup>41</sup> The results indicated that Fluoxetine is an effective treatment for PTSD. Although fewer studies have been done to determine the effectiveness of using SSRI medication to treat traumatized children, J.D. Kinzie and P. Leung reported that their quantitative research indicated that Clonidine significantly reduced avoidance, startle responses, and trauma related depression in children.<sup>42</sup> A later study by R.S. Pynoos and K. Nader involved a random sample and control group of children diagnosed with PTSD, and reported that Clonidine reduced persistent arousal symptoms in traumatized children.<sup>43</sup> A third study by R.J. Harman and P.D. Riggs using the same criteria, reported the same results.<sup>44</sup>

In summary, researchers agree that PTSD results when an organism's adaptive response to danger becomes dysregulated.<sup>45</sup> Studies indicate that such dysregulation is related to changes in cortisol production, and that exposure to prolonged stress is a contributing factor.<sup>46</sup> Changes in brain morphology have been associated with PTSD, and physiological changes in the brain have been linked to an ongoing vulnerability to further psychopathology.<sup>47</sup> These issues are of concern to victims of child abuse since critical

brain development occurs during childhood years, and physiological changes could represent permanent damage, leading to a lifetime of vulnerability to psychopathology.

### **Cognitive/Behavioral Perspective on Post-Traumatic Stress Disorder**

K. Chase Stovall-McClough and Marylene Cloitre write that the Cognitive/Behavioral perspective on PTSD arises from the concept that experience consists of a matrix of affective memories.<sup>48</sup> As new events occur they are stored within that matrix according to the individual's prior experience. Since trauma is outside normal experience, the assimilation of trauma into this matrix is problematic. Elissa J. Brown et al. note that the PTSD symptoms of re-experiencing trauma, such as nightmares and intrusive memories, or in the case of children repetitive trauma-related play or trauma re-enactment, are considered to be the trauma survivor's effort to integrate the new experience into the preexisting matrix of affective memories.<sup>49</sup> Richard Meiser-Stedman states that Cognitive/Behavioral psychotherapeutic (CBT) techniques are directed toward facilitating this assimilation. Such assimilation conceptualized in this way may not be possible for a child who suffered abuse from birth or at a young age since a pre-trauma matrix of affective memories would not exist in that instance, thus emphasis for such children is placed on healthy accommodation of trauma memories into new experience.<sup>50</sup>

Stovall-McClough and Cloitre write that the Cognitive/Behavioral model for understanding PTSD proposes that a traumatic experience is initially stored in memory as an associative network of stimulus-response features, and that external sensory stimuli related to the trauma, such as sights, sounds and smells, are incorporated into the experience of the individual.<sup>51</sup> These stimuli have the potential to evoke memories of the



trauma causing an individual to respond as if the past experience of the trauma were happening currently. McKeever and Huff write that stimulus response features can be thought of as *cognitive distortions*, and that cognitive distortions present in adults with PTSD contribute to those individuals' experience of having a pervasive quality of decreased control over external eventualities, thereby reducing their resilience to further trauma.<sup>52</sup> Aaron Beck defines cognitive distortions as faulty assumptions held in place within the larger matrix of a faulty belief system.<sup>53</sup> Meiser-Stedman notes that children, as well as adults, experience cognitive distortions arising from trauma.<sup>54</sup> However, in children the etiology and manifestation of those cognitive distortions is influenced by the developmental stage of the child at the time of the trauma. Meiser-Stedman cites Pynoos et al.'s theoretical essay on this point, noting that the authors stress the importance of the development of language in particular on a child's experience of trauma.<sup>55</sup> Pynoos et al. assert that young children who experience trauma before language is fully developed lack verbal memories of traumatic events, whereas older children with more developed "linguistic and cognitive abilities" have access to verbal memories. As a result, older children are able to process trauma more like adults. AJ. Azarian et al., as a result of their study of young children exposed to an earthquake, noted that their subjects displayed what the authors referred to as *non-verbal memories* consisting of: repetitive trauma-related play, nightmares that could not be described, and physiological and somatic reactions.<sup>56</sup> The authors assert that the development of verbal memories in older children may provide a protective barrier against the ongoing detrimental effects of non-verbal memories. Brown et al. write that symptoms resulting from trauma do so because fear-related emotional images relating to trauma are incorporated into the child's cognitive

*schemata*, or belief systems.<sup>57</sup> Beck describes schemata as mental structures which integrate and attach meaning to events.<sup>58</sup> Tim Dalgleish further defines the notion of schemata as an “associative network of affect and cognition.”<sup>59</sup> Allison Harvey hypothesizes that it is an individuals’ paradoxical experience of enduring a traumatic event for which they have no context which is associated with their psychopathological response to the trauma.<sup>60</sup> Stovall-McClough and Cloitre suggest that when trauma material remains unassimilated in an individual’s experience it becomes stored in the memory of the victim in a network of associated sensory triggers, and that when an individual comes into contact with these triggers they experience a strong anxiety response as if the trauma were currently occurring.<sup>61</sup>

In terms of how this causes an anxiety response in adults, A. Ehlers and D.M. Clark suggest that the response consists of a particular type of anxiety which they term *current threat*.<sup>62</sup> Ehlers and Clark postulate that this is related to the individual’s perceived situation in relationship to their current world view and the resulting degree to which they feel powerless. In terms of how this concept translates to children, especially young children who are the victims of child maltreatment and may not possess a pre-existing pre-trauma matrix of affective memories into which to assimilate a new traumatic experience, J.S. Bishop suggests that his research indicates that a traumatic event has little bearing on such a child’s “assumptive world.”<sup>63</sup> Meiser-Stedman suggests that traumatized children may cope with their distress by simply rejecting assumptions about the world which threaten their security.<sup>64</sup> S.D. Hollon and J. Garber assert that for such children the goal of CBT is to promote healthy accommodation rather than assimilation of trauma experience, and caution that that without treatment directed

towards that end maltreated children may attempt maladaptive accommodations, such as telling themselves that what they experienced did not constitute abuse.<sup>65</sup>

CBT interventions emphasize assimilation or accommodation of trauma related memories and utilize techniques in order to facilitate this process. Brett T. Litz et al. describe these techniques as *cognitive reframing* or *restructuring*, and *exposure therapy*.<sup>66</sup> Alan S. Gurman and Stanley B. Messer provide more detail writing that: restructuring or reframing is a method by which individuals are able to make adjustments in their thought processes to include the new traumatic information in adaptive ways; exposure therapy involves traumatized individuals exposing themselves to trauma related stimuli in an effort to desensitize them to such stimuli, and cognitive reprocessing involves individuals integrating their trauma within their experiences and belief systems.<sup>67</sup> Dagleish contends that exposure based interventions provide a method for PTSD sufferers to systematically confront the objects of their emotional distress within a predictable and safe framework resulting in desensitization to those stimuli thereby decreasing the trauma related response.<sup>68</sup> He notes that interventions involving restructuring or reframing target the PTSD sufferer's interpretation of their trauma, and encourage a reinterpretation of the traumatic event. Laurence Miller notes that PTSD symptoms in adults and children are particularly amenable to treatment using graded exposure therapies, known as *systematic desensitization*, during which a patient gradually confronts trauma related stimuli that they would otherwise avoid.<sup>69</sup> Miller suggests that such stimuli can be represented in imaginary ways in a clinical setting, or in vivo, for instance by revisiting the trauma site. In terms of young traumatized children whose trauma occurred when they had little or no developed language, A.W. Burgess et al. note that such children's traumatic memories

were stored somatically and visually and recommend exposure therapy utilizing the same senses, such as the use of pictures, and play involving art and movement.<sup>70</sup>

CBT interventions have been widely studied to determine their efficacy and researchers have claimed evidence of their success. Nancy McWilliams writes that since these interventions have discrete and observable behavioral units there is a great deal of empirical data which is largely lacking for other interventions, such as psychoanalytic interventions.<sup>71</sup> McWilliams emphasizes that this does not mean that CBT interventions work and psychoanalytic ones do not, just that they have been the most widely studied.

In terms of the helpfulness of CBT interventions for treating traumatized children, a literature review of treatment studies compiled by A.E. Kazdin and J.R. Weisz supports an overall success.<sup>72</sup> In particular, Kazdin and Weisz assert that symptoms related to complex PTSD resulting from chronic child abuse respond positively to CBT interventions. Norah C. Feeney et al. also note that there is evidence of the success of CBT interventions in the treatment of child abuse victims.<sup>73</sup> Feeney et al. cite several studies to that end, including research initiated by M. Celano et al. involving 56 randomly selected, sexually abused girls, aged eight to 13 years.<sup>74</sup> Celano et al.'s research utilized exposure therapy with pictorial representations of the abuse, cognitive restructuring involving modifying self-blame attributions, and psychoeducation. The study included a control group utilizing supportive therapy and psychoeducation. Improvement was noted in both groups. A second study cited by Feeney et al. was initiated by E. Deblinger and J. Lipmann, and involved 19 sexually abused girls ages three to 16.<sup>75</sup> The intervention consisted of 12 sessions of gradual exposure to abuse related memories. Participants reported improvement, and none met criteria for a diagnosis of PTSD following

treatment. Building on Deblinger and Lipmann's success, J.A. Cohen et al. constructed a two site, randomized study involving 229 children with PTSD symptoms related to sexual abuse, and compared CBT with supportive counseling.<sup>76</sup> Prior to treatment, nine percent of the children were diagnosed with PTSD. Results indicated that children benefited from both therapies but the CBT interventions reported significantly greater improvements. Although there are positive results for the techniques involved in CBT interventions treating PTSD, studies indicate that their success remains dependent on a positive therapeutic alliance. Pynoos and Nader emphasize the importance of this relationship particularly in the case of traumatized children, and write that the establishment of rapport with such children is a crucial ingredient to successful treatment.<sup>77</sup> Cloitre reports that in CBT interventions treating PTSD, as well as with other treatment modalities, the therapeutic alliance is the "most consistently identified predictor of psychotherapy outcome."<sup>78</sup>

In conclusion, CBT techniques facilitating assimilation or accommodation of traumatic material for the purpose of addressing the symptoms associated with PTSD and complex PTSD can be said to be effective. However, research indicates that this effectiveness is dependent on a positive relationship between the therapist and client.

### **Psychodynamic Perspective on Post-Traumatic Stress Disorder**

Psychodynamic theorist Anna Freud posited that an individual's response to trauma includes the development of unconscious psychological defenses whose purpose it is to protect the individual's sense of a core self.<sup>79</sup> Sigmund Freud contended that the oscillating PTSD symptoms of numbing and avoidance, and re-experiencing are

considered by psychodynamic theorists to be alternately an attempt to recover and assimilate repressed trauma memories, and an effort to protect the psyche from the overwhelming affect engendered by such material.<sup>80</sup> Bowlby's attachment theory emanated from psychodynamic theory, and represented a theoretical departure from psychodynamic theorists' conceptualization of individuals as motivated by unconscious drives, and a realization that an individual's response to traumatic events is affected by their interactions with the environment, particularly their early relationship to a primary caregiver.<sup>81</sup> James Garbarino et al. contend that a positive relationship to an early caregiver assists a child in developing resilience to trauma by allowing the child to develop psychological resources, whereas faulty or interrupted attachment predisposes a child to later psychopathology.<sup>82</sup> Theories related to attachment are of significance to child abuse victims since the abuse itself may represent an interruption in attachment to a primary caregiver, as suggested by Cloitre et al.<sup>83</sup>

A. Freud writes that psychodynamic theories are "preeminently a psychology of the unconscious."<sup>84</sup> She suggests that trauma results in unconscious psychological defenses becoming constructed with the purpose of protecting the individual against further disruption, and contends that these psychological defenses were effective against the original trauma, but remain unchanged long after the trauma has ceased. Naming this process, *permanent defense phenomena*, A. Freud describes it as a "vigorous defensive process from the past which has become disassociated from its original situation." She states that defenses resulting from trauma, including the experience of child maltreatment, may manifest as habitual behaviors or character traits which quickly become archaic since they are so intractable. Kalsched concurs, and writes that

psychological defenses resulting from trauma are maladaptive since once they are in place they remain fixed and are “not educable” and do not modify themselves in the face of new trauma. Kalsched alleges that as a result, “the traumatized psyche is self traumatizing.”<sup>85</sup> Paul Tolpin further discusses the purpose of trauma related defenses, alleging that they arise in order to protect an individual’s core sense of self.<sup>86</sup> Tolpin writes that individuals have an overwhelming instinct to protect their experienced sense of a cohesive self, and will use whatever psychic resources are at their disposal in order to do so. D.W. Winnicott also writes about the preservation of a sense of self, asserting that a perceived violation of the inner core of the personality that is experienced as self is unthinkable, and it is the response to this which results in the development of psychological defenses in response to trauma.<sup>87</sup>

S. Freud writes about an individual’s response to trauma terming it *traumatic neurosis*, and noting that it has the components of anxiety and fright, and occurs in individuals after life threatening events.”<sup>88</sup> S. Freud describes the etiology of traumatic neurosis in the following way: he opines that individuals have a protective psychological shield enabling them to comprehend and cope with stimuli coming from the outside world, and that trauma can be considered to be events outside the normal experience with accompanying stimuli too significant to be protected against by this psychological shield, the last resort of which is anxiety. S. Freud asserts that anxiety can be considered to be an adaptive response to trauma since it has the capacity to alert an individual to danger, and it remains adaptive until it becomes so intense that it overwhelms the individual; when this occurs, traumatic neurosis results. A crucial ingredient of S. Freud’s psychodynamic theory is his identification of psychosexual

stages of development, namely: the oral stage, the child's first year of life when a child's pleasure and frustration revolve around the mouth; the anal stage related to toilet training during the second year of life; the phallic stage during years three to six, where aggressive feelings and fantasies associated with the genitals predominate; the latency stage occurring at the end of the phallic stage and before puberty, and during which sexual and aggressive impulses are relatively quiescent; and finally the genital stage, when a type of maturity is reached and genuine relationships are formed.<sup>89</sup> S. Freud notes that individuals who have experienced trauma tend to become stuck in the psychosexual stage in which it occurred.

In terms of the avoidant and numbing symptoms related to PTSD, S. Freud hypothesizes that an individual's attempt to psychologically bury conflicted affects resulting from trauma in the unconscious constitutes an effort by that individual to not experience uncomfortable feelings, or "non-pleasure."<sup>90</sup> Regarding the re-experiencing symptoms of PTSD, S. Freud writes that individuals suffering from traumatic neurosis tend to dream of it repeatedly in recurrent nightmares. Such dreaming constitutes an attempt to master the traumatic stimulus retrospectively by summoning up in dreams the anxiety that was missing in the initial experiencing of the event. Carl Jung, having examined his own dreams, agrees with S. Freud that dreams are essential in resolving trauma related issues in the unconscious which cannot be resolved consciously.<sup>91</sup> Jung writes that unresolved trauma constellates in the unconscious in the form of a *complex*. By the word complex, Jung refers to a collection of thematic associations resulting from unconscious mental contents which have constellated into a belief system.<sup>92</sup> Jung contends that psychic trauma produced complexes with very strong emotional charges



and the associated traumatic material is kept firmly in the unconscious.<sup>93</sup> He suggests that traumatized individuals react from the consciousness of this complex rather than from a more lucid understanding of the current moment.

S. Freud terms the impulse of traumatized individuals to repeat aspects of their traumatic experience *the compulsion to repeat*, and theorizes that such behavior results from an instinctive reaction by individuals who cannot remember all of what is repressed within themselves.<sup>94</sup> S. Freud writes that individuals repeat a contemporary experience using the repressed material rather than remembering it as something belonging to the past. Since such action seems so antithetical to healing from the trauma, he goes on to theorize that the reason for this compulsion is the “concurrent and mutually opposing action of Eros, the instinct for self preservation, and Thanatos, the death instinct.”<sup>95</sup> Gil notes Lenora Terr’s notion, that the compulsion to repeat manifests in children in terms of actions, such as a reenactment of trauma, or repetitive play symbolizing trauma.<sup>96</sup>

Dissociative symptoms have been noted to a way in which the numbing and avoidant symptoms associated with PTSD manifest. Jung suggests that dissociation is related to trauma being incorporated into unconscious complexes.<sup>97</sup> Kalsched suggests that mild dissociation is the psyche’s normal reaction to a traumatic experience, and represents the withdrawal of the psyche from the scene of the injury, for instance in the case of a state of shock following a traffic accident.<sup>98</sup> Kalsched contends that if such dissociation is not possible, such as in chronic child abuse, then a part of the individual’s core self withdraws and more severe dissociation occurs resulting in destructive psychopathology. Kalsched describes a child’s dissociation resulting from ongoing, chronic child abuse as, “a fragmentation of consciousness in which the different pieces

organize themselves according to certain archaic patterns. These fragments do not communicate with each other and are dissociated from a cohesive whole.”<sup>99</sup> Kalsched states that in such situations typically one part of the personality regresses to an infantile period, and one part progresses, or grows up too fast, and then attempts to caretake the regressed part.

Studies have indicated a correlation between faulty attachment, and a predisposition for vulnerability to PTSD. Bretherton writes that attachment theory represents the culmination of the ideas and work of Bowlby who developed his theory in the 1940s.<sup>100</sup> His thinking was considered revolutionary and controversial at that time since it represented a shift in perspective of psychodynamic thinkers. Mary Ainsworth was an essential contributor to the theory. In addition to expanding the theory itself, her innovative methodology made it possible for Bowlby’s ideas to be tested empirically, and therefore gain greater acceptance.<sup>101</sup> In Bowlby’s paper regarding attachment theory, “The Nature of the Child’s Ties to his Mother,” he outlines his rejection of the current psychoanalytic explanation for children’s libidinal ties to their mothers in which need satisfaction is considered primary, and proposes that emotional attachment is primary instead, as evidenced by behaviors such as sucking, clinging, and following.<sup>102</sup> Howard Bacal describes this shift in psychodynamic thinking to a more relational way of understanding child behavior.<sup>103</sup> Bacal opines that early psychodynamic thinkers tended to think of people as self contained individuals influenced entirely by instinct-like drives coming from within themselves, and considered the effects of trauma on children from the perspective of the development of their individual drives. Bacal contends that later psychodynamic theorists noted that the effects of trauma included the interaction of

children with their environment, including with their early caregivers. P. Tyson comments on this point, claiming that the shift of perspective from S. Freud's drive theories to a more relational approach involved a recognition of the importance of intrapsychic experience on the development of children.<sup>104</sup> McWilliams describes this recognition of the connection of children with their environment and caregivers as "the ubiquity of human connection, of our embeddedness in an interpersonal system where our sexual and aggressive nature is only part of the story."<sup>105</sup> This shift in perspective provided the backdrop for the development of feminist relational theory, developed during the 1970s and representing the work of scholars associated with the Stone Center for Developmental Services and Studies at Wellesley College as described by Judith V. Jordan et al.<sup>106</sup> Such notions represented a departure from earlier Freudian thinking, as well as from the ideas of later psychodynamic thinkers who still relied on the relationship of an individual's sense of self with an external object, often a mother. Jordan et al. note in particular the work of Carol Gilligan in writing about the centrality of the relationship itself and the sense of connection to others, particularly for women.<sup>107</sup> Gilligan notes that for both men and women it is the "primacy of responsive relationships which are the determinants of psychological reality."<sup>108</sup>

Bowlby discusses how attachment is related to emotion regulation in children by describing that during a child's early years, the mother provides the function of emotion regulation.<sup>109</sup> Without a mother's guidance during that time, children fail to accomplish successful regulation on their own. Cloitre asserts that the emergence of emotion regulation skills is guided by caretakers through activities such as labeling and interpreting emotional experiences, soothing activities, and role modeling of effective

mood regulation.<sup>110</sup> Child abuse may interrupt this process, and a lack of these skills can result in a lifetime of mental health problems. These ideas are reflected in Winnicott's notion of the "good enough mother." Winnicott writes that the good enough mother begins by entirely adapting to the infant's needs and, as time goes on, adapting less and less thus allowing the infant to accommodate her failures.<sup>111</sup> This process allows infants to integrate their experience, learn to tolerate frustration, and learn the difference between self and other, including the notion that other is not in their immediate control; thus leading to the infant's abilities to regulate their emotions. Garbarino et al. write that the results of their research indicates that children who receive compensatory doses of psychological nurturance are better able to develop social competence, self esteem, and stress resistance, and are therefore less likely to develop PTSD in the face of trauma.<sup>112</sup> Sylvia Brinton Perrera echoes this notion and opines that the capacity of an individual to endure discomfort is related to an early experience of being held intimately and with respect, and that such actual and symbolic holding creates a strong enough ego to both suffer and enjoy future experiences.<sup>113</sup> Cloitre posits that childhood abuse by primary caregivers represents faulty attachment.<sup>114</sup> Wendy Ide-Williams writes that there is an inherent irony in the attachment figure being also the perpetrator of violence and abuse, since the need for a child to attach is so great.<sup>115</sup> Ide-Williams suggests that the resulting unbearable paradox engenders competing emotions of fear and anguish. Children caught in this conundrum have no choice but to attune themselves to their abuser's inner states, and remain unable to engage in normal social interactions which might provide relief.

Psychodynamic interventions utilized with traumatized children attempt to facilitate a bridge between the conscious and the unconscious, and often involve Play

Therapy. S. Freud compared the play of children to a “poetic creation” and, although he did not use play himself, he recommended the utilization of play for child analysis.<sup>116</sup>

Regarding S. Freud, S. Kern notes that “one of the great ironies in the history of analysis is that S. Freud, who laid the foundation for twentieth century child psychiatry never personally analyzed a child client.”<sup>117</sup>

E. James Anthony et al. note that the earliest description of psychoanalytic treatment of children was published in 1921 by Hermione von Hug-Helmuth, who wrote that play therapy using toys and other creative means was the only way to treat younger children, and remained helpful with older children.<sup>118</sup> Dessie Oliver James notes that it was Melanie Klein and Anna Freud who most clearly shaped the practice of play therapy as the primary means of psychoanalytic treatment for children.<sup>119</sup> Melanie Klein writes about play therapy noting that in this modality “the child not only overcomes painful reality, but at the same time it also uses it to master its instinctual fears and internal dangers by projecting them onto the outside world.”<sup>120</sup> A. Freud utilized play extensively in her psychoanalytic work with children. Specifically she recommended toys for children with limited verbal skills to use in order to access their inner world.<sup>121</sup> Regarding using playing as a therapeutic medium, Winnicott writes that “in playing, and perhaps only in playing, the child or adult is free to be creative.”<sup>122</sup> Winnicott suggested that play occurs in what he refers to as *transitional space*. The concept of this space emerges initially from the mother/child relationship without fully belonging to either mother or child.<sup>123</sup> Winnicott describes play as “neither a matter of inner psychic reality, nor a matter of external reality,” in this way it occurs within transitional space where nothing is known for certain, and everything can be created.<sup>124</sup> Winnicott notes that such

transitional space is only available within the context of a relationship since it is interpersonal. Virginia Axline writes that play is the natural medium of self expression for a child, and this is what must be used for a child to access “accumulated feelings of tension, frustration, insecurity, aggression, fear, bewilderment, and confusion.”<sup>125</sup>

Richard Kagan notes that young children most easily connect with traumatic experiences by using arts and crafts, and other play items to create enactments of events in their own ways, and appropriate to their understanding of an event.<sup>126</sup> Lisa Herman eloquently provides an example of this in her description of her treatment of a four-year-old girl who was a victim of brutal sexual abuse by her father.<sup>127</sup> Using toys, created figures, and enactments, and blending the imagery of fairy tales with the four year old’s trauma experience, Herman was able to assist her young client in expressing the horror of her experience. Sometimes the use of art in the treatment of children is more directive, for instance in the “House-Tree-Person Test” developed by J.N. Buck in 1948, and elaborated on in 1969 by J.N. Buck and E.F. Hammer.<sup>128</sup> This test is administered by asking an child to draw each of the items in turn. Since images of these three objects have the potential to be emotionally laden depending on an individual’s experience, Buck, and later Buck and Hammer, assumed that affective information could be derived from the drawings, and they developed standardized ways of interpreting the renditions of the objects. In spite of this standardization, R.C. Burn’s later thoughts on these images is that they can be regarded in a more open way and interpreted more spontaneously.<sup>129</sup> Journal writing is also recognized as a form of therapy. Kathleen Adams refers to this as the act of writing down thoughts and feelings to sort through problems.<sup>130</sup> She notes that in recording and describing life events and issues, one achieves a heightened understanding.

Kay Bradway and Barbara McCoard write that *sandplay* is the natural extension of play therapy.<sup>131</sup> Dora Kalff's development of sandplay therapy draws on the same principles, those of providing a medium for the expression of experience which utilizes symbol and metaphor in order to provide a language for the unconscious.<sup>132</sup> Sandplay consists of making three dimensional pictures in a tray of sand using miniatures. Writing in the forward of D. Kalff's book on the subject, her son Martin Kalff writes that "non-verbal therapy provides direct access to unconscious material."<sup>133</sup> M. Kalff notes that while a child is engaged in creating a symbolic scene in the sand tray using miniatures, their conscious mind relaxes its control and allows them access to unconscious material lying below the surface, transformation takes place as a result of this connection with unconscious psychological material. Bradway and McCoard write that D.Kalff presented the purpose of the sand tray to be a forum for children where they "could be free to be who they truly were, and protected so they could do what they needed to do."<sup>134</sup>

Working within the paradigm of play therapy, *transference* and *countertransference* reactions between the therapist and the child inform the progress of the therapy. Jung describes these concepts in the following way: "The elusive, deceptive, ever-changing content that possess the patient...flits from patient to doctor...as a third party in the alliance."<sup>135</sup> Gil defines transference as the "relocation of thoughts and feelings about a primary person in the child's life to the clinician," and countertransference as the clinician's response to this.<sup>136</sup> She notes the importance of continued awareness of these unconscious processes and their purpose in identifying the emotions of the child which underly their behaviors. Related to the concept of transference is the notion of the importance of the therapeutic relationship, particularly

when working with traumatized children. J. Herman writes about this emphasizing that traumatic experience engenders feelings of powerlessness, and disconnection from others.<sup>137</sup> As a result, healing can only take place within the context of a relationship. Herman goes on to say that within the therapeutic alliance, the trauma survivor re-creates “the psychological faculties that were damaged or deformed by the traumatic experience.

In conclusion, psychodynamic theories regarding PTSD examine the relationship of the disorder with unconscious psychological processes, particularly psychological defenses developed at the time of the trauma. Psychodynamic thinkers agree that psychopathology associated with PTSD is the result of those defenses becoming fixed in an individuals’ unconscious affecting their responses to current events. Predisposing factors for the developing PTSD include disorganized or interrupted attachment with early caregivers. Psychodynamic therapeutic modalities involving young children utilize play and art as mediums for children to express themselves without words.

### **Sociocultural Perspective on Post-Traumatic Stress Disorder**

Leroy H. Pelton notes that individuals living in situations of social adversity, such as in violent inner city areas or areas beset with chronic poverty, are more likely to be exposed to a trauma.<sup>138</sup> Donald Lloyd writes that different racial groups are no more likely to develop PTSD except when as a result of their racial group, they are at the lower end of the socioeconomic strata.<sup>139</sup> Studies such as the one by I Wolock, and B. Horowitz have shown that child abuse is one of the traumas which occurs with more frequency in groups struggling with social adversity, and that it has been shown to be a predisposing factor to future psychopathology, including PTSD.<sup>140</sup>



Pelton asserts that child abuse occurs most frequently in families struggling with issues of daily living.<sup>141</sup> In order to support this claim, Pelton cites statistics gathered in 1975 and compiled by the American Humane Association in Denver, CO.<sup>142</sup> Pelton asserts that these statistics indicate that the most prevalent characteristic of families in which children are victims of abuse, is poverty. Pelton contends that while abuse has the potential to occur in any family, it is much more likely to occur in families struggling with issues of social adversity. Further, he addresses the argument that since poor people are more likely to be “susceptible to public scrutiny and thus more likely to be reported for abuse or neglect,” the data may erroneously include an over reporting of poor people. Pelton cites his own 1978 statistics claiming that they refute that assumption.<sup>143</sup> He notes research by Wolock and Horowitz exploring the rates of child maltreatment and material deprivation among families receiving government aid, and alleges that this research finds a clear correlation between the degree of poverty and the degree of abuse.<sup>144</sup> Wolock and Horowitz write that those families “involved in child abuse and neglect cases were found to be living in more crowded and dilapidated households, were more likely to have gone hungry, and to be existing at a lower material level of living than other families studied.”

Regarding sociocultural conditions as a contributing factor in exposure to traumatic events, Lloyd et al. explored the experience of a sample of 1,803 young adults in the Miami Dade region of Florida.<sup>145</sup> They reported that their findings supported the notion that children living in high crime, inner city areas were at greater risk for developing PTSD following a trauma since they were more likely to have experienced prior trauma due to their surroundings. They asserted that “disadvantaged social status is associated with both significantly elevated risk for the experience of multiple adversities,

and a resulting greater risk for PTSD.” Lloyd et al. alleged that there were racial implications in their research since African American and Cuban individuals were overrepresented at the lower end of the socioeconomic level in their sample. Lloyd et al. hypothesized that the social status of these groups resulted in greater social stress and trauma related to social adversity, resulting in an increased vulnerability to PTSD. They opined that race in this context was a social rather than a biological categorization, and it was the relationship of race to social status that was the most relevant factor.

Regarding poorer social conditions as a contributing factor to developing PTSD, K. Horowitz et al.’s exploration of PTSD symptoms in urban adolescent girls living in areas where there was a pattern of community violence led them to coin the term *compounded community trauma* in order to explain the phenomenon of the increased risk of PTSD for children who live in such environments.<sup>146</sup> In spite of these increased risks, Horowitz notes that there are mitigating factors for individuals living in socially stressful situations. N. Gonzales and L. Kim also note such mitigating factors and write that extended family networks, spirituality, and strong cultural identity provide ameliorating factors for the phenomenon of compounded community trauma.<sup>147</sup> Jeremiah A. Schumm et al. concur, citing the results of their study of inner city women with a history of child abuse as indicative that community adversity can contribute to the propensity to develop PTSD, but community support may provide a buffer.<sup>148</sup>

Child abuse can be associated with socially stressful situations. Research cited earlier has indicated that a history of child abuse correlates with an increased risk of developing PTSD, and that chronic poverty and living in unsafe, violent, and insecure environments are contributing factors to an increased likelihood of child abuse. Colin

Pritchard conducted a study examining this phenomenon which set out to examine the efficacy of British Child Protective Services by assessing homicide and other data collected by the World Health Organization between 1973 and 1988.<sup>149</sup> Pritchard reported a clear correlation between social stressors including poverty and unemployment, and incidences of child abuse. N. Scheper-Hughes discusses this phenomenon citing the results of her study exploring the experience of children in Brazil with attention to material scarcity and caregiving of children.<sup>150</sup> At the time of her research, Scheper-Hughes reported that 80 percent of the population lived in poverty. She measured the basic infrastructure of family life in terms of parent-child attachment, parental self-esteem, and stability of access to shelter, food, and medical care. She reported that her research indicated that higher infant mortality rates, and rates of abandonment and exploitation of young children directly correlated to the material deprivation of the children's caregivers. Regarding the idea that the ability of caregivers to cope in the face of trauma is correlated with the potential of children to develop psychopathology, S.B. Wasserstein and A.M. La Greca assert that their research involving children who had survived a hurricane indicated that parental support is one of the most important mitigating factors deflecting PTSD, and the absence of caregiver support has a profoundly deleterious impact on a child trauma survivor.<sup>151</sup> A. P. Mannarino and J.A. Cohen concur, and hypothesize that the ability of caregivers to manage stressful situations is a predictor of whether children develop PTSD following sexual abuse.<sup>152</sup> Mannarino and Cohen measured family cohesion, adaptability, the intensity of parents' reactions to the abuse, and the level of emotional support to the children, and found that such measures were strong predictors of treatment outcome.

Trauma must be considered to occur within the context of an individual's life. B. D. Perry and I. Azad assert that it is the manner in which an individual perceives an event which constitutes whether it is a trauma, and this perception is mediated by an individual's culture, developmental stage, personality, family cohesion or support, previous traumatic events, type of traumatic event, and prior psychiatric history.<sup>153</sup> In addition to these considerations, Garbarino et al. point out that child abuse itself is a social judgment related to the culture in which the incident happens: that is, such maltreatment must be considered within that culture to be inappropriate and of jeopardy to the child. Further, perception of danger itself is subjective and related to its cultural surroundings.<sup>154</sup> This notion is supported by Rojas et al. who state that the relationship between stress and resulting disorders is contextual and must take into account the social structure in which it occurs.<sup>155</sup> Dana Becker writes that "Options available to us in coping with stress are shaped by the sociohistorical context" of an individual's life, and the ways in which individuals express distress in terms of how they deviate behaviorally from accepted social norms are historically and socially determined.<sup>156</sup>

It has been noted that PTSD is more frequently diagnosed in females than in males, and that females tend to report sexual abuse more frequently than males. B.I. Green asserts that demographic data gathered in a clinical and epidemiological study on gender differences in PTSD indicates a greater risk of PTSD occurring in girls when compared to boys.<sup>157</sup> In their review of PTSD research studies, David F. Tolin and Edna B. Foa examined 290 studies of both adults and children culled for reliability from a pool of 2,477 studies.<sup>158</sup> Based on their analysis, Tolin and Foa found a twofold risk of PTSD among females compared with males, even when considering the finding that males were

more likely to report a potentially traumatic event. Tolin and Foa hypothesized that females may be more likely to experience the forms of traumatic events which lead to PTSD, and that sexual assault or abuse is reported more frequently by females. Rojas et al. suggest that, for children, it is possible that the development and expression of PTSD symptoms is related to gender depending on familial or cultural expectations of children, since gender has a role in shaping the coping style of an individual.<sup>159</sup> Rojas et al. go on to postulate that girls' symptoms may better fit the current diagnostic criterion than boys' symptoms since girls demonstrate more internalizing and dissociative symptoms in the acute response phase to trauma than boys. In comparison, boys externalize their symptoms in ways not accounted for in the current diagnostic criterion.

In summary, studies have shown that the sociocultural conditions create circumstances in which an individual is more likely to be exposed to trauma, thus causing a predisposition in that individual to develop psychopathology in the face of further trauma. Sociocultural conditions which expose an individual to social stressors, such as violence or chronic poverty, have been shown to constitute such conditions. In addition, research has shown a correlation between social stressors, in particular chronic poverty, and increased incidences of child maltreatment.

### **Imaginal Approaches to Post-Traumatic Stress Disorder**

Imaginal theorists' approach to viewing PTSD embraces many of the concepts put forth in the other perspectives, and utilizes myths and archetypal imagery in order to gain greater perspective of the process. Imaginal thinkers discuss the effects of trauma and other psychopathology in relationship to issues of the soul.

During classes at the Institute of Imaginal Studies, Aftab Omer has described trauma as an experience which taxes physical and psychological abilities, and involves the creation of psychological defenses which become fixed and maladaptive over time.<sup>160</sup> Omer refers to the ongoing maladaptive behaviors resulting from these defenses as the “larger story piercing through into our lives in a way that causes the local story, or self, to rattle,” thus creating a need for an individual to pay attention to the underlying causes of such behaviors. *Imaginal Transformation Theory* (ITT) was developed by Omer and emanated from the thinking inherent in the imaginal approach to psychology.<sup>161</sup> One of the key concepts inherent in the theory is the *imaginal structure*. Omer writes that imaginal structures can be understood as “assemblies of sensory, affective, and cognitive aspects of experience constellated into images; they both mediate and constitute experience.”<sup>162</sup> He notes that this term is a way to describe the lens through which an individual views their world, thus becoming the clay which shapes their experiences, and that imaginal structures manifest in sensory, affective and cognitive ways, as well as in cultural and archetypal ways, and that parallel concepts include schemas and personal myths.<sup>163</sup> This concept is of importance to child maltreatment victims since the enveloping nature of such trauma creates an imaginal structure affecting their entire worldview. Mario Jacoby describes the result of such trauma writing that: “Trauma involves the rupture of developmental transitions that make life worth living.”<sup>164</sup>

Omer has stated that reclaiming soul is Imaginal Psychology’s primary concern, and that the vehicle for this reclaiming is imagination.<sup>165</sup> He contends that symptoms resulting from trauma result in a suppression of imagination, thus a separation from soulful expression. The term soul has been defined in various, complementary ways. The

definition utilized by Omer within ITT is the following: “Soul refers to the mysterious stillness, aliveness, and otherness at the core of being.”<sup>166</sup> Jung contends that soul can be described as the numinous resonance within an individual’s experience, and understood as divine consciousness, or the archetype of God.<sup>167</sup> Jung writes that psychology is intrinsically a study of the soul which is the refractor of this divine consciousness. Jung relates the concept of *self* to the notion of soul, and describes self as a psychological idea describing an “unknowable essence” which defies description. He notes that trauma can be understood as a profound disruption of the self as it is related to soul. James Hillman provides a description of soul, noting that it can be thought of as a “differentiated idea referring to a reality of great impact.”<sup>168</sup> Hillman writes that soul is a perspective rather than a substance, and “shares a frontier with religion” since it has a relationship with death. It is soul’s relationship with death which adds significance to events deepening them into experience. The idea of soul, Hillman contends, involves the concept of consciousness resting “upon a self-sustaining and imagining substrate,” and that it is the unknown component which makes life meaningful.

Kalsched asserts that understanding archetypal and mythical symbology related to complex trauma is critical in understanding the resulting pathology and primitive psychological defenses.<sup>169</sup> Kalsched cites Mogensen on this point who writes that individuals faced with profound trauma reach for the numinous.<sup>170</sup> In other words, individuals faced with events that their imagination cannot contain will reach for a larger archetypal story. Jean Houston provides a definition for the term *archetype*, noting that archetypal images include a sense of cultural and ancestral essence.<sup>171</sup> She asserts that archetypes constitute codings of the deep unconscious, constellations of psychic energy,

and patterns of relationships, and can be thought of as “the great relatives from whom we derived, who gave us existence, prompted our stories, and elicited our moral order.”

Houston notes that archetypes become personified as mythic characters within stories, and frustrate analysis since they can only be known through direct experience. Hillman describes archetypes as metaphysical symbols of the “deepest patterns of psychic functioning... axiomatic, self-evident images to which psychic life and our theories about it ever return.”<sup>172</sup> Omer has described archetypes as “the deepest ordering principles,” and the “deepest order of what is arising from the source (of all existence).”<sup>173</sup>

Kalsched uses the archetypal figure “The Trickster” in order to represent the nature of the defensive process that results from trauma.<sup>174</sup> He describes the Trickster as having the qualities of the god Mercurius, or Hermes, whom he notes is an entity with a paradoxical nature and the capacity to be either a persecutor or a protector, capable of bringing great pain but also great good. Jung also uses this archetype in order to describe these archaic defenses.<sup>175</sup> He notes that Mercurius/Hermes has a mythological ability to cross all boundaries thus allowing him access to unconscious psychological material usually only available to individuals indirectly in dreams and fantasies. Like Kalsched, Jung contends that Mercurius/Hermes is capable of invention and malice, and that he has a dualistic nature which enables him to assist in the transformation of unconscious material. The Trickster archetype relates to the way in which imagination can be awakened in order to assist with the transformation of unconscious trauma experience for children. Omer discusses imagination noting that it represents the creativity of the soul, and can facilitate a reconnection with soulful expression following trauma since it allows individuals to amplify their experience in ways which encourage integration of



experience.<sup>176</sup> Pat B. Allen writes that “imagination is the deepest voice of the soul...and a relationship with our imagination is a relationship with our deepest self.”<sup>177</sup> Thomas Moore asserts that “imagination is the primary activity of the psyche.”<sup>178</sup> Omer contends that if imagination is repressed, integration of traumatic material cannot occur.<sup>179</sup> Kalsched concurs, saying that this is especially poignant for victims of child abuse since ongoing trauma crushes the capacity for symbolic imagination and the symbolic play upon which children rely, replacing it with a type of dissociation.<sup>180</sup>

Winnicott describes the dissociated response of traumatized children resulting from suppressed imagination, and refers to it as “fantasying,” which he asserts does not involve imagination in the same way that symbolic play does.<sup>181</sup> Winnicott defines fantasying as a means to disappear into an imaginary world in the midst of a present experience. He differentiates fantasying from actively using imagination by saying that in the case of fantasying, there is never a whole person there to be aware of two dissociated states that are present at one time. In other words, there is no capacity for insight by an individual engaged in fantasying; thus it becomes a psychological dead end since “it has no poetic value, it simply maintains the ongoing stuckness of the traumatized individual by providing an avenue to avoid strong affect.”

Gil notes that symbolic play can be utilized to engage a child’s imagination in working through the trauma, particularly since it is symbolic play that is often stifled as a result of trauma.<sup>182</sup> D. Kalff utilizes sandplay in order to assist children in finding a Mercurial medium to provide access to the contents of their unconscious.<sup>183</sup> D. Kalff writes that when children use miniatures and symbols to build scenes in the sand-tray they have no choice but to utilize archetypal metaphors connecting their experience to

wholeness, thus moving towards wholeness in themselves. She asserts that the symbols used by children in this manner, are the same ones which have been used by humans throughout the ages. It is this utilization of the Trickster's ability to cross all boundaries via sandplay, and the archetypal symbols used to connect with wholeness which brings about transformation. D. Kalff uses her work with a traumatized boy in order to illustrate this point. She contends that when this child was able to use sandplay in order to access the instinctual traumatic material buried in his unconscious, divine archetypes began to appear in his sand-trays. Kalff makes the point that "it was only in relationship to the divine that this adolescent was able to fully accomplish the transition to adulthood."<sup>184</sup>

Stephen Levine and Ellen Levine describe this process in the following way: They assert that imagination has the capacity to take a child "beyond and behind everyday life," so that when traumatic experience is re-enacted it is not simply a recreation of the trauma, rather it utilizes the child's language and perceptions in order to provide a tapestry of experience, weaving past, present and archetype thus evoking deeper meanings with the capacity to transform.<sup>185</sup> S. Levine and E. Levine write that imagination itself embodies the nature of the Trickster. This concept is illustrated in L. Herman's description of her treatment of a four-year-old sexual abuse survivor.<sup>186</sup> She assisted her client in developing a forum to re-enact her traumatic experience and wove it into the fabric of an archetypal fairy tale, thus she linked past experience with present perception and both with the greater archetypal story, the result was transformation.

Kalsched opines that the purpose of the Trickster archetype within the defensive system resulting from trauma is a dual one consisting of protecting the core self from being destroyed by the trauma while being ready to destroy the self if it comes under

attack, even to the point of killing the host body by committing suicide.<sup>187</sup> Kalsched suggests that the Trickster is able to shapeshift into whatever form the individual's psyche needs it to be in order to convince it to believe in whatever is necessary to protect its sense of self. In terms of how this notion relates to traumatized children, J. Herman writes that repeated trauma in childhood necessitates that children adapt to their situation in impossibly paradoxical ways.<sup>188</sup> For instance they must find ways to trust people who are untrustworthy, and compensate for their caregivers' lack of ability to care for them. J. Herman contends that such experience results in children building pathological psychological defenses which "form and deform (the child's) personality." These defenses are best described using the language of the supernatural. In other words, their profound nature can only be represented by archetypal images. Kalsched writes that such defenses allow for the survival of the self at the expense of personality development, effectively repressing imagination, and providing protection against the original trauma, while paradoxically impeding healing.<sup>189</sup> Jon Mills discusses the impossible position a victim of child abuse by their caregiver finds themselves in. Mills writes that personality can be understood to be composed of unconscious organizational processes which are in a constant state of flux, and are responsive to their environment and provide functional semblances of continuity, and self cohesion.<sup>190</sup> Childhood maltreatment at the hands of primary caregivers results in profound disruption of these processes, the consequence of which is that children experience their self structure as fragmented, or depleted, resulting in intense psychic pain, accompanied by acute feelings of helplessness, shame and humiliation. Mills notes that the response to such trauma results in a "damaged core, dislocated and polluted," leaving an individual with limited psychic resources.

Moore notes that the mythological process of alchemy is a useful way to understand the healing from this type of traumatic response.<sup>191</sup> Moore writes that alchemy can be described as “a natural process of transformation ... Alchemy begins with a descent into the stuff of everyday life, but it ends...with the release of a winged spirit. Alchemy is a way of imagining the release of spirit from the thick of matter.” The way in which interrupted attachment to early caregivers has been noted to damage a child’s resilience in the face of trauma is discussed by Edward Edinger utilizing alchemical imagery.<sup>192</sup> Edinger suggests that when a child does not have adequate attachment to a primary caregiver there is a gap in the child’s psychic landscape in which an essential archetypal image has not been personalized, leaving such children with a deficit within their personality structure. Edinger relates the process of early attachment to the alchemical stage of coagulation where more ethereal substances are made solid, noting that attachment to early caregivers represents a developmental stage when external relationships are internalized within the psyche. Edinger uses the phrase “archetypal contents fall out of heaven and are egoized,” in order to describe this process.<sup>193</sup>

Hillman writes that the reliving of trauma in order to heal trauma such as the repetitive play of traumatized children, is equivalent to mining the alchemical salt of the trauma.<sup>194</sup> In other words, healing involves utilizing the very material which caused the wounds in the first place. Moore concurs, writing that traumatic experiences contain the potential of generating transformative gold.<sup>195</sup> Edinger refers to the alchemical stage of *Coniunctio* as symbolic of the transformative process of healing from trauma.<sup>196</sup> Edinger states that *Coniunctio* consists of combining two substances in order to create a third, and different substance. Kepner relates the alchemical phase of *Coniunctio* to the CBT

desensitization/exposure techniques for trauma victims.<sup>197</sup> Desensitization, Kepner suggests, is a process during which the unfinished business of trauma is joined with current experience in order to facilitate adjustment to the present. Jung relates this to the concept of *Coniunctio* which brings together opposites, as in coitus, merging in some irreversible and transformative way in order to produce a third substance.<sup>198</sup>

For children who are victims of abuse, their loss of connection with their caregivers can be represented in mythic terms. In the case of the subject of this Clinical Case Study, the loss was related to the rupture of the mother/child relationship, which evoked a deep sense of yearning. Such learning was mirrored in the refracting surfaces of the myth of Demeter and Persephone. Penelope Prodow and Barbara Cooney note that in this mythic story Persephone, the beloved daughter of Demeter “the goddess who turns the seasons and bestows the life-giving fruits of harvest on mortals,” is stolen from her mother by Hades, god of the underworld.<sup>199</sup> The separation of each from the other evokes a yearning, and a rupture in the circle of the relationship described by Doris Orgel as “the circle...of mothers and daughters...which is all around, always.”<sup>200</sup> The character of Demeter is further described by Malcolm Day as Mother Earth, sometimes known as Gaia, whose mythic task it is to ensure that the seasons happen as they should, so that crops can grow in order to feed the population of mortals.<sup>201</sup> Thus representing an ordering and life-giving force which provides nurturing and sustenance.

In summary, imagination can be considered to be the way in which soul expresses itself, and trauma results in a suppression of imagination. Key imaginal theorists note that imagination is a vehicle for healing, and suppression of imagination interrupts recovery from trauma. Understanding this process through the lenses of myths and archetypal

imagery provides a depth of insight for traumatized individuals, allowing them to consider the meaning of their trauma in a larger context. For children who have experienced trauma, symbolic play utilized in therapy, and awakening imagination, can provide such archetypal awareness.

### **Conclusion**

All of the perspectives regarding trauma acknowledge that the symptoms of PTSD consist of an oscillating pattern of re-experiencing traumatic memories alternating with numbing and avoidant symptoms, and that individuals with a past history of trauma or psychopathology are more likely to develop PTSD in the face of further trauma. Researchers differentiate between symptoms related to a single incident trauma and complex symptoms from ongoing trauma, such as child maltreatment.

Biological researchers contrast maladaptive physiological, and neurobiological responses with normal, adaptive responses to trauma, noting that all mammals have a profound response to trauma often aiding them in escaping the danger or pain engendered by such trauma. Biological studies indicate that chronic trauma exposure is particularly likely to result in problematic responses including changes in brain morphology or production of cortisol, a hormone noted to be important in maintaining the adaptiveness of the stress response. Cognitive/behavioral thinkers also acknowledge that a strong response to trauma is normal, and contend that this response becomes problematic when thoughts and affective memories relating to the trauma fail to become assimilated or accommodated in an individual's experience. Cognitive/behavioral theorists opine that the oscillating symptoms of PTSD represent attempts to assimilate or accommodate such

memories. Thinkers from the psychodynamic perspective concur that trauma reactions have the potential to be adaptive, but note that trauma survivors tend to develop strong unconscious defenses which arise at the time of trauma as a coping mechanism, but become maladaptive over time. Attachment theory which emanated from psychodynamic thinking asserts that faulty attachment to early caregivers in connection with child abuse represents a contributing factor to vulnerability for later development of PTSD. Research from all perspectives indicates that prior exposure to trauma increases vulnerability to development of PTSD. Sociocultural researchers suggest that the social conditions in which an individual lives may increase the risk of exposure to trauma; further, individuals living in chronic poverty or without social supports experience greater stress contributing to a higher likelihood of child maltreatment and resulting psychopathology. Imaginal thinkers acknowledge these issues utilizing mythology and archetypal images in order to relate them to the broader human experience. Imaginal writers emphasize the importance of expressions of the soul, and note that trauma symptoms have the potential to compromise such expression, but that the involvement of imagination can mitigate this.

All of these angles from which PTSD can be viewed are relevant to the subject of this Clinical Case Study, Sally, who suffered ongoing and chronic child maltreatment and was diagnosed with PTSD. Sally currently suffers from the oscillating symptoms mentioned as well as the more complex symptoms related to child maltreatment. As a result of her early experience she is vulnerable to develop further symptoms in the face of later trauma. Sally's treatment involved utilizing her imagination in order to express her experience and move towards wholeness.

## **CHAPTER 3**

### **PROGRESSION OF THE TREATMENT**

#### **The Beginning**

The initial meeting that I had regarding my patient was with her then foster mother, Lucy, who presented as a competent, energetic woman whose enthusiasm for her soon-to-be-adoptive daughters was evident. During this meeting, Lucy reported to me that she had divorced before she had children and was determined that this would not prevent her from fulfilling her dream of motherhood. In order to fulfill that dream, Lucy contacted a local foster/adoption agency which placed Sally and May into her home. Lucy related that she was committed to the success of this adoption and therefore was doing everything that the foster/adoption agency was instructing her to do, including bringing Sally to psychotherapy. Lucy expressed horror at the abuse and neglect that Sally and May had endured, and noted that her awareness of this made her ever more committed to them.

The immediate treatment priorities included assisting Lucy in dealing with some of Sally and May's most troublesome and disturbing behaviors, and providing her with some parenting support. Lucy described her frustration when Sally had what she described as "knock-down-screaming tantrums." Lucy reported that while Sally was making "a noise like a banshee," all her parenting training was forgotten. Lucy described Sally's tantrums to me saying that the triggers were sometimes unpredictable, but that one common precipitant involved Sally having difficulty with a homework assignment.



Lucy reported that Sally was very perfectionistic regarding schoolwork, and often seemed unable to tolerate the frustration of being unable to complete assignments. Lucy said that Sally's tantrums consisted of her screaming inconsolably, sometimes for hours. She said that Sally sounded like a much younger child when she screamed like that, and occasionally she would become angry and destroy things, mostly her own possessions; for instance if she was frustrated with her homework she had a tendency to rip it into bits.

Lucy also provided details regarding Sally and May's sexualized behaviors. She reported that the sexual acting out was usually initiated by May, and would occur often if May thought that she and Sally were alone. Lucy related that as far as she could tell, May would take off her own clothes and get on top of Sally and start humping her. Lucy had already reported that Sally sometimes had a "dead" or blank look, and Lucy reported that when she had caught May and Lucy doing this, Sally had that same look. The assumption that Lucy made, that May was the initiator in these sexual encounters, seemed plausible since unlike Sally, May had been accused of doing the same thing with other children.

In addition to these difficulties Lucy reported that Sally had ongoing problems with peer relationships and frequent conflicts with friends at school. Lucy related this to Sally's anger management issues, although she said that recently Sally had successfully befriended a neighbor girl who was three years younger than her. Lucy expressed concern about Sally's propensity to tease animals, and again reported that on those occasions when she had caught Sally kicking the cats or hitting the neighbor's dog with a stick, she had the same faraway look she that did when she and May were engaged in sexualized behaviors.

Lucy had already hired an in-home behavioral consultant to assist with techniques to handle Sally's frequent and intense tantrums, and so we discussed how it was for Lucy to implement his suggestions. Lucy noted that he had recommended providing redirection for Sally and May's sexual behaviors in a non-shaming way, and assisting them with their night time fears and nightmares by using nightlights. At his prompting, Lucy installed baby monitors in each of their bedrooms and encouraged Sally and May to use them in order to call to her in the night if they were scared. Lucy's patience and imagination in dealing with Sally and May's difficult behaviors was impressive. Since these interventions were being followed by the behavioral consultant, they were not included in my own treatment of Sally.

### **Treatment Planning**

Lucy and I agreed that Sally would see me for weekly individual psychotherapy. Psychotherapy was to include play therapy, sand tray, art therapy, and journaling in order to provide Sally with the possibility of finding an opportunity to express herself freely and explore her inner world using the metaphorical language of imagination. Emphasis was placed on ensuring that the therapy took place as consistently as possible, at the same time and on the same day of the week, so that the notion of the therapeutic container as a safe and trustworthy setting for Sally to explore her inner world with its traumatic associations was implied by its predictability.

In keeping with the orientation of the Children's Therapy Project, much of the therapy was envisioned from a psychodynamic perspective utilizing transference and counter transference, and working within the context of the therapeutic relationship. I

anticipated that my awareness of the intersubjective experience of our relationship would assist me in joining with Sally as she explored her inner experience. My consciousness of the shifting kaleidoscopes of transference and countertransference reactions would be reflected in my responses to her, and assist in my capacity to keep our relationship available as a holding container for Sally. The dictionary definition for the word “container” is “a box, jar, or bottle that is used to hold something, especially when it is being transported.” This definition fits well the purpose of the treatment approach and the therapeutic modalities which I chose as a means to transport Sally through the journey of her psychotherapy.

### **The Therapy Journey**

Sally was slender, blonde child, with big brown eyes, and an easy and infectious giggle. She was receptive to her therapy from the first meeting, coming eagerly and curiously into our first session. Although in my opinion establishing an adequate therapeutic alliance is essential in any therapy, in Sally’s case it was apparent from our first meeting that our relationship and the establishment of a safe and consistent therapeutic container was to be crucial in Sally’s treatment. Her wounding had come about through the rupturing of important relationships, and I felt that her healing would also come about within the context of a relationship. In order to create a safe therapeutic container so that Sally could address her trauma, my challenge was to communicate my imperfection and therefore vulnerability as a human to Sally, while at the same time demonstrating my consistency and reliability. For Sally, knowing that I had the capacity to be moved by her experience would provide encouragement for her to express her

feelings, while the maintenance of a forum in which to do this would allow her to feel safe in doing so.

During our first therapy session, I pulled out a small table in order to have a surface to draw on. As I pulled it out, one of the table legs fell off. Sally laughed and laughed and has not forgotten that moment which epitomized the nature of our relationship and provided evidence of the above mentioned qualities, apparently successfully. An ongoing theme of testing and maintaining the safety and trustworthiness of the therapeutic container continued throughout our therapy sessions. For instance, for several of our initial meetings Sally was fascinated by the fact that my office was a place where she could see out but others could not see in, since it had windows on two walls which were mirrored on the outside in order to deflect sunlight. For Sally, this fact appeared to contribute to her notion that my office was a protected space. Throughout our work together, every so often at Sally's request, we spent some time in session looking out of the windows of my office and occasionally waving at people in passing cars, or at pedestrians. I would comment on the fact that they could not see us, and encourage Sally to engage in vigorous waving in order to reinforce her observation that they did not react or give any indication that they could see us. Sally remained interested and reassured by the idea that she could see them but they could not see her.

About four months into our treatment another incident occurred which appeared to be a test of the reliability of our relationship. On this occasion I had cancelled a prior session at short notice because I was ill. Sally came into the following session clutching a slightly grubby piece of paper, all folded up. After Sally had got herself her usual snack, I asked her what the piece of paper was. She told me that she had an argument with a

friend. I asked what that had to do with the piece of paper she was holding. Sally was again vague about the piece of paper, saying only that she thought that everything was all alright now. I asked Sally if the piece of paper was a letter from her friend. She replied that it probably was, since it was in her friend's handwriting. We proceeded with our session as usual. After Sally had gone, I noticed that she had left the piece of paper on the couch, it was screwed up into a ball but placed right in the center of the couch cushions where I would be sure to see it. I opened it up and read in Sally's handwriting "Virginia is nice." It seemed that Sally had been able to express anger with me for canceling a session by saying that she had an argument with a friend, but that her note represented a repairing of the rupture in our relationship. Sally's comfort level in sessions continued to increase following this incident, evidenced by a growing playfulness with me. I, too, as a result of this incident felt a deeper trust in the reliability of our relationship and a growing confidence in the worth of our particular therapeutic journey together.

The content of our sessions was a further contributing factor to the structure of an adequate therapeutic setting. Throughout the first year of therapy our sessions had a ritualistic quality in that we did the same things in the same order every time, although what we did within those activities varied. I believe that, for Sally, containing our therapy within these rituals contributed to her sense that she could express powerful and frightening feelings within a known and safe container. Such repetition seemed typical of the play of a traumatized child, but it was creative rather than stuck since within each activity Sally built on the experience of the last session. The pattern of the actual activities repeating themselves while Sally remained in charge of their content afforded

her the potential of a sense of empowerment within the therapy session which I hoped would generalize out into her life.

How these rituals came to be was somewhat of an organic process. Although at the onset of our work together I had certain therapeutic activities in mind, I encouraged Sally to choose how she wished to express herself. The therapeutic tools I utilized included sand play, journal writing, and various art projects. Sally would come into every session either with a snack already in hand or I would give her one of our agency-provided snacks consisting of cheese flavored goldfish crackers and a juice drink. She would consume this snack while chatting to me about her week as a prelude to our session. Following this activity, she would spend a moment or two looking out of my office windows in the manner described above, make a sand tray, write in her journal, do some artwork, and then play a game. This routine did not vary at all for some time, even though I would always ask Sally what she would like to do in case she wanted to do something different.

Within the safety of our routine, themes relating to Sally's trauma began to emerge. One such theme was food and the availability of it. Food themes appeared often in Sally's artwork and sand trays. For instance, one piece of artwork that Sally made was a collage about her life containing the four most important elements identified by her. The elements she chose to represent in this collage were: food, family, friends, and animals. Sally carefully cut from magazines pictures of all kinds of food, not just the cakes and candy one might expect from a child her age, but other foods like broccoli, carrots, and grapes. On another occasion she drew pictures prompted by evocative sentences provided by me. One of the sentences I provided was: "What do you daydream

about?” In response Sally drew pictures of food including spaghetti, vegetables, and fruit. Another sentence was “Where would you go if you were invisible?” Sally’s response, in her own spelling: “I will go to a restront!”

The following incident occurred somewhat later in our therapeutic journey. The snacks that our agency provides consist entirely of baked crackers the shape of goldfish in various flavors. One version of these is a cheese flavored variety, but in multi-colors. We did not usually get this version, but every so often Sally would find herself with a bag of these as her snack. The first time this happened, before finishing the packet she became engrossed in her sand tray, then later in some artwork and a game, and finally noticed with surprise towards the end of the session that there were still goldfish crackers left in her bag. She said with a grin, “they must be magic, this is a bottomless bag.” Following that incident, every time Sally found herself with a bag of the multi-colored crackers she made the comment that it was a magic bag. I came to notice a particular quality in the sessions where Sally claimed that she had a magic bag of goldfish crackers. Sally seemed more able to be spontaneous and playful. Perhaps risking more since her food source was assured by magic.

Connected to the idea of food is the idea of nurturance. The food Sally ate as we began our sessions was sometimes provided by her adoptive mother, and sometimes by me. I felt that this perhaps represented a means by which Sally could acknowledge that these two figures in her life were sources of nurturance and dependability. In one of our early sessions Sally did something which reinforced this belief, she dictated a story to me, and then illustrated it herself. The story was entitled “Find the Fox,” and went as follows:

One day there was a fox and he got lost, and it was about to rain. But his friend the bear gave him a warm fire and some food. They went into a cave. Even

though it was still raining they had hot chocolate. The next day his parents found him and they went home and had a good day. The End.

This little story seemed so resonant to me. I wondered if it was Sally's story of being rescued from the distress of her earlier life and eventually being found by Lucy, or perhaps her experience of being psychologically and spiritually nourished in therapy, and then going home to the safety of Lucy's care, or perhaps all of these woven together. Most poignant was the story's resolution: the fox and his parents ended up "having a good day." As I noted earlier, I always offered Sally her artwork to take home if she wanted to, or, if not, I put it in a locked drawer in my office which Sally was aware of. I felt that Sally intuitively knew which of her creations were more directly symbolic of her trauma, and best kept safely in my office. In order to assist her with these choices, I would frame my offer for Sally to take things home by saying something like; "Do you want this to go home with you, or do you want me to keep it safe for you?" Sally chose to take this particular story home with her.

For the full first year of treatment, and in the majority of the sessions following, Sally completed a sand tray during sessions. The theme of the reliability of food sources, and the importance of a mother-child connection were reflected in those sand trays. Time and again her sand trays were filled with groupings of animals involving mother animals next to young animals, and adjacent to a food source appropriate to the animal. Sally would provide me with a running commentary as she made these sand trays, apparently needing to ensure that I understood the significance of her use of the miniatures. For instance, if she put an adult giraffe next to a baby giraffe with a nearby tree she would say something like, "This is the Mommy giraffe, and this is the baby giraffe, and this tree is for the giraffes to eat." As she did this, I would offer the comment that the baby animal



could feel safe now, since it had something to eat and someone to protect and take care of it. Another recurring theme for Sally in her sand trays was a treasure of some kind heavily guarded by benign but fierce beings from bad or malevolent figures trying to get it. Sally would often use my miniature of a treasure chest to represent this treasure, and sometimes she would use a handful of small, colored glass hearts, or a combination of the two. I assumed that the alternating symbols of the treasure chest and the hearts were a clue to the nature of the heavily guarded treasure. (Illustrations 1a and 1b)

Since this treasure chest theme occurred so frequently in Sally's sand trays, I decided to try to expand the symbols for greater expression. I bought a larger, treasure-chest shaped box made of plain, brown card stock, and suggested that Sally decorate it. Over the course of several sessions we decorated it together. Sally asked me to help her, and I did so by coloring in spaces at Sally's direction and with Sally's choice of color. Sally chose all the pictures and stickers, and placed them herself. She decorated the top of the treasure chest by writing her name boldly and placing a sticker of a girl in a Far Eastern "Genie" outfit, telling me as she did so that this was the outfit she had worn last Halloween. Also on the top she included stickers of happy puppies playing by themselves, and of flowers.

Each of the four sides of the treasure chest was a representation of Sally's version of a season. Sally told me that the four seasons consisted of: Halloween, Christmas, Easter, and her birthday. On the bottom of the treasure chest, in large capitals she wrote: "I love animals!" The inside of the chest was decorated with stickers of small, wild animals including several rabbits and mice. Mother and baby animals were represented together: An owl and her owlets, a mother bear and cub, and a doe and fawn. Beneath the

doe and fawn sticker Sally had placed an illustration she chose from a magazine, a cut open pomegranate with seeds revealed. Inside the treasure chest was a gift that I had chosen and placed inside, a large red glass heart inspired by the smaller glass hearts she had used in her sand tray. (Illustrations 2a and 2b) After we completed the treasure chest, I painted it with shellac at Sally's request in order to keep the stickers on, and offered it to her to take home. Sally opened it up and said that she did not want it since it smelled like wine, presumably the smell of the shellac. Following the making of the treasure chest Sally took home many of the other items and pictures that she has made, but she continued to insist that the treasure chest remained in the locked drawer in my office.

Sally made three drawings early on in our relationship consisting of a person, a tree, and a house. (Illustrations 3a, 3b, and 3c). Sally's drawing of a person consisted of a girl whom she described as herself, though the picture looked very different from Sally. The girl was dressed neatly with black hair and fairy wings; Sally is usually a messy dresser, and is blonde. I noticed how different this girl was from Sally, and wondered what the wings might represent for her. I commented on this, but Sally simply said, "It is me." Sally's rendition of a tree appeared solid, but with a deep hole in the middle of the trunk within which she drew some black lines. Sally reported that the black lines represented a squirrel. However, they looked to me much more like an anguished face. Surrounding the tree, and flying in the air, were four birds. Again, I noticed the theme of wings. Sally had very little to say about this picture. The house that Sally drew was a square structure with no windows, just a door, and flowers drawn over and around it. When I brought Sally's pictures to my consultation group, the facilitators noted that Sally's house drawing resembled the one in the story *The Three Little Wolves, and the*

*Big Bad Pig.*<sup>1</sup> In the story the three little wolves build various homes out of various materials. Each house they build is blown down by the big bad pig who is jealous of the wolves' homes. Finally, the wolves build a house entirely out of flowers. Obviously the house is fragile enough for a pig to blow it down with no trouble; however, the wolves hope that it is so beautiful the pig will fall in love with the house and not blow it down. The pig does just that, and they all live together happily ever after. At our following session Sally confirmed that she had drawn the house with this story in mind, and that it was a story she loved. Beyond that, she had no further comment.

In our subsequent session, Sally made a request to write another story in the same way that we made the "Find the Fox" story. She stated that she would dictate it to me, and I should write down her dictation leaving room for her to illustrate it. Sally seemed to have thought about what she wanted to do ahead of our session, and was determined to complete this project. Sally's story was entitled, "The Story of the Fairy Princess" which she spelled as "Pressess." Sally made the illustrations with a combination of stickers and drawings. Her illustrative representation of the Fairy Princess involved an image of a girl with wings reminiscent of her earlier picture of herself. She dictated that the Fairy Princess lived in the forest, and one day was scared by a mountain lion. The image that Sally chose to represent the mountain lion was actually a mother bear and bear cub sticker rather than a mountain lion, even though there was a lion sticker available. Sally wrote that some friends came to help to scare the mountain lion away. However, they did not kill the mountain lion; rather they drugged him with medicine so that they could take him to the zoo where "he stays forever so he doesn't hurt anyone." Sally again used a mother and child sticker, this time of beavers, in order to represent her mountain lion.

Lastly, and poignantly, her final dictation read “and the Fairy Princess became Queen, because she did a good job by herself without her mom and dad, and her friends lived happily ever after, even the lion.” (Illustrations 4a, 4b, 4c, 4d, and 4e) I felt so proud of Sally following her telling of this powerful little tale. I was aware of the sadness of being a lost child without parents, but the strength of having friends and allies to help, and the courage to do things alone. It evoked my own grief regarding my mother, and awareness and gratitude to those who had stepped in to fill the gap she left. There was a strong pull to do the same for Sally. Shortly after completing this project, Sally asked to work with something heart-shaped. I managed to find a plain brown card stock box shaped like a heart. (Illustration 5). Sally seemed delighted by the find, saying that it was exactly what she needed. She carefully drew a jagged line across every heart-shaped surface of the box, and told me that it was a broken heart. It seemed to me that the grief in the story of the Fairy Princess needed greater expression. This was one of the art projects that Sally wanted to take home. She told me that she was going to keep her most precious things in this box.

All of these projects were framed in the therapy ritual which I described earlier, the importance of which remained throughout our treatment. One particular incident demonstrated to me irrefutably the importance to Sally of the predictability of the ritualistic routine of our therapy sessions. On this occasion, Sally and May’s adoptive mother, Lucy, was not available to bring Sally to her appointment with me. As a result, Lucy allowed an adult male friend of hers, “Alan” (pseudonym), who was well-known to Sally and May, to bring her to the appointment with me. Lucy had envisioned that while Sally was seeing me, Alan and May could go and pick out a pizza for dinner, after which

they could pick up Sally from her appointment and meet Lucy back at their home.

Although Alan was someone Lucy absolutely trusted, given Sally and May's prior history of sexual abuse, they were very wary of being alone with any adult male. Lucy did not grasp the enormity of the apprehension that Sally and May might feel in such a situation. May had managed to remain calm with Alan as long as Sally was there, but as soon as it became apparent to May that she was to be left alone with him while Sally was in her appointment with me, May began to cry and refused to let Sally leave. I suggested to Alan that rather than go and get pizza he and May should wait in the waiting room of our office while I met with Sally, and I would keep the door to my office ajar in an effort to provide May with some reassurance. However, May refused even that accommodation. Sally asked if May could come into our session. Since it seemed the only way for Sally to have even a brief meeting with me I agreed, and Alan waited outside. Once in the therapy room Sally asked if I would play with May and reported that she would take care of our therapy. Puzzled, I followed Sally's lead and took May into a corner of my office with some Play-Doh. Meanwhile Sally followed our previously established routine without me. Sally got herself a snack which she shared with May, then looked out of the windows, made a sand tray, and wrote in her journal. I was moved and impressed by the way in which she had internalized our ritual. While I was not fully present with Sally as usual, my attention being distracted by May, I felt that Sally had been able to complete what had become an important punctuation for her week, and a touchstone for her psyche. Sally had also provided me with an opportunity to witness her caretaking behavior of May, and I had no doubt that this had been going on for Sally since May was born, after all, Sally is three and half years older than May and their biological parents

did not sound like competent caregivers. I found myself reflecting with horror on what it might have been like for Sally to listen to, and perhaps witness, May being raped by their father. I was also awestruck by Sally's ability to not only take care of May in this situation, but also to do what she needed to do for herself. My confidence in Sally and in the therapeutic process grew exponentially following that experience.

My psychotherapy with Sally also involved journal writing. Not wanting to push Sally, but wanting to give her an opportunity to express what she needed to about the past at her own pace, I had the idea to give her a journal. My thought was that we would start writing in the middle recognizing that as the present, and the space from the beginning of the journal to the middle would be to write down memories of the past as they occurred to her, thus providing her with a medium to reclaim her history and organize the chronology of her life. In addition, perhaps providing a means for her to express potentially traumatic memories as much as she felt comfortable in doing so. I was Sally's therapist through two birthdays; her 10th birthday and her 11th birthday. On each occasion we had a celebration and I gave her a new journal for the year to come with the hope of continuing to provide her with a method to explore difficult memories, and express her feelings about the present. The journals that I gave her were always included a small padlock and key. I was careful to let Sally be the one to unlock her journal and lock it up again; hoping to foster in her a sense of the journal being exclusively hers, and as private as she needed it to be with the information contained therein protected.

With very few exceptions, Sally did not want to remember the past, and created her journal as if her life began when she was adopted by Lucy. In general while using her journal Sally was very focused on chronicalling her new life in her adopted family. For

instance, her rendition of the first Fourth of July celebration when she had her journal, which would also have been the first Fourth of July with her new adopted family, included, amongst much glitter representing fireworks, careful drawings of the various adoptive cousins and aunts and uncles present with their names and relationship to her written next to their pictures. Sally was also very clear that she wanted the correct date written on her journal page, again perhaps to her orient to her new life. My sense was that Sally was using the journaling experience largely to make sense of her current life and new family. It also seemed to me that in order for Sally to feel comfortable in exploring the past she first had to focus on establishing a solid platform in the present, and the journal provided a medium for that. With very few exceptions, one of which I will describe, Sally was happy to leave the first half of the journal blank. I was very non-directive as I assisted her with this project, merely asking her what kinds of pens or drawing equipment she was going to need, and helping her with spelling or dates if she asked for such help. Sally always wanted to show me her journal entries, wanting to share her pride in her new family.

One of the few incidences of Sally's life before she joined Lucy's family which she shared with me included a story about eating a snake. She drew the event in her journal in one of the spaces reserved for journaling about her "life before her adoption." The drawing was very rudimentary in comparison with her drawings of her adopted family, consisting of just a few undecipherable lines. At first Sally seemed enthusiastic when she told me the story. She insisted that she did indeed eat a real snake and told me that her uncle found it when they were camping. She said that she took a bite and it moved in her mouth because it was still alive. I found this story very disturbing, and at

the time Sally told me I was unsure what Sally was trying to say; for instance this memory could represent for Sally an incident of sexual molest, or witnessing thereof, or a conquering of some inner demon, or a literal memory of eating a snake. I tried to remain neutral and open in my response merely repeating back what she was saying in order to let her know I had heard her. I said something like, "So, your uncle found a snake when you were camping, and you ate it." I am not sure whether my repeating of this in this way was too overwhelming for Sally, or my acknowledgement of the occurrence made it too uncomfortable for any further discussion of it, but as soon as I made the comment Sally stopped talking about it and shut the journal, and wanted immediately to do something else. For the remainder of that session we just played a game of Connect Four, which is a type of three dimensional tic-tac-toe. Sally seemed disconnected and quiet during the game. This was unusual, since she was good at this game and winning usually made her giggle. However, the game itself seemed an appropriate activity following Sally's disturbing story, since the rules are very clear and predictable and the grid-like structure of the game board itself reflects that. In addition, this was a game we played together often and there may have been some comfort for Sally in returning to a familiar routine after sharing her snake story with me. Following that incident I was concerned that my response to her had been too neutral and that I had inadvertently broken her trust. Conversations with my consultation group regarding this issue were reassuring, and helped me to see that Sally was expressing some of the darker aspects of her trauma in artwork, and in her sand trays, and that it was imperative that she should unpack this at her own pace and in her own way.



Another phenomenon which occurred during treatment was that following almost all of our sessions we would go out into the waiting room and Lucy would be sitting waiting in one of the chairs, but May would be hiding somewhere, perhaps under a table or chair, or outside the door. Lucy was always a very good sport during this part of the session, joining with May in her “joke”, saying things like, “Oh May is at a friend’s house,” or “May is at home cooking dinner.” Of course Sally did not believe her, and both Sally and I spent some time “finding” May after each session.

Sally did not usually get overtly angry, or cry during our sessions. There was only once instance where she showed up with tear-filled eyes. Lucy said that she had a tantrum in the car on the way related to something unknown that May did. Sally was reluctant to talk about what had occurred but for the duration of this session she departed from our usual routine and instead asked me to just read stories to her. I have a large book of fairy tales from around the world, Sally in wanted me to read in particular a story involving a young girl who would not listen to her mother and was accidentally turned into a fish as a result. The story relates the young girl’s struggle in her water-bound world to find a way to turn back into a girl again so that she can return to her mother. While the story does have a happy ending, I felt moved by Sally’s potential for grief, and for her yearning for comfort. My own grief was evoked, and its presence helped me hold Sally’s experience.

### **Legal and Ethical Issues**

Sally and May moved through the process of becoming legally adopted during my treatment with Sally. Their adoption was made final in 2006. During that time, the holder of the privilege of confidentiality shifted from Social Services to Lucy as the legal parent

of Sally and May. While Social Services held the privilege of confidentiality, the person responsible for giving me permission to receive information was the attorney representing Sally. This attorney was almost impossible to contact and actually knew very little about Sally, since the various social workers working with her were the individuals in direct contact with Sally. Another ethical concern regarding the adoption process was the fact that Sally and Lucy very much wanted me to be present at the moment of her adoption. As I have mentioned, with the support of my consultation group, I decided that there was potential therapeutic benefit to Sally from my presence at her adoption, since I could represent a sense of continuity for her having known her both before and after her adoption. A possible negative consequence of my presence at her adoption might be that Sally could assume that I approved of her adoption, and hesitate to discuss conflicted feelings which she may have regarding her adoption. I decided to attend the legal portion of the adoption, but forgo any following celebrations, since that might constitute a duality of role.

As a result of attending the legal portion of the adoption I was able to briefly meet other members of Sally's adoptive family; such as her grandparents, Lucy's parents, and her aunt and uncle. Sally was proud of these people and seemed reassured that I had met them. The result of my decision to attend her adoption seemed to be positive, and provided Sally with a sense that all the individuals in her life who form her support system knew each other, and were working together. Following her adoption, there was a sense that Sally was more relaxed. Lucy reported to me that her tantrums at home had decreased. Within the context of the therapy sessions her need to maintain our rituals also relaxed, although it did not entirely disappear. Over the ensuing months, Sally slowly

began referring to Lucy as “Mom”. At first, she only wrote the word in her journal, but eventually she began to say it out loud. It seemed a very natural progression. In addition, she changed her name which was spelled out in large letters on the front of her journal to her new last name, Lucy’s last name. In one particular session shortly after the adoption session, she made a great show of signing her name over and over.

How much to share with Lucy about Sally’s therapy and for what purpose was an ethical concern that demanded considerations of the limits of confidentiality. Lucy did not need to know the specific content of our therapy sessions, however her daily challenges consisted of coping with some of the more difficult aspects of Sally’s behavior including; difficulties with peers at school, tantrums, and teasing animals. As a result, it seemed important to Lucy to provide me with regular reports about Sally’s behaviors. I was concerned that if Sally felt that I was the recipient of a regular report of what she might perceive as bad behaviors on her part, our therapeutic relationship might be damaged. In order to avoid this, I requested that Lucy only give me information by telephoning me from her place of work where there would be no chance of Sally overhearing. In addition, I made clear to Lucy that I would not share with Sally what she had told me so that I would not be perceived by Sally as partnering in a parent-like way with Lucy in order to correct behavior.

A further ethical consideration which emerged as a result of deciding to use Sally as the subject of my Case Study was the fact that she was a minor, and therefore not eligible to provide evidence of informed consent. Although her adoptive mother was very supportive of this study, Sally could understand its purpose. With this in mind, I

attempted to be sensitive in the composition of this study honoring Sally's experience while taking particular care to guard her identity.

### **Outcomes**

From the beginning, and throughout our therapy journey, Sally always looked forward to our meetings often reminding Lucy if she feared that Lucy might forget. Sally's enthusiasm spoke to the success of building an adequate therapeutic container, meaning that Sally's experience was safely held and there was a sense that she could express herself. This was made evident to me by the degree to which Sally felt increasingly comfortable becoming assertive in asking for what she needed in order to express herself; for instance when she directed me in helping her write a story which resulted in "The Story of the Fairy Princess," and when she asked to make something heart-shaped. Apparently Sally had been able to feel comfortable enough within the therapy sessions to notice the deep stirrings within herself which needed expression, and then seek out a means to express them.

Within the delineated therapeutic time and location I attempted to follow Sally's lead in the direction and flow of the therapy since from a psychodynamic perspective, the expectation was that her unconscious would reach for what it needed in order to heal, and my job was to facilitate that possibility. While it was evident that Sally's psyche was manifesting in her art, story writing, and sand trays, there was also a suggestion that she was trying to present herself to me in a likeable way. Rarely did she show any difficult or unpleasant emotions. This was reflected in her journal writing, which almost always related good things that were happening while skipping over anything that was not fun,

and also in her self-portraits which were representations of pretty girls with features unlike her own. It was possible that Sally's love of the story of the *Three Little Wolves and the Big Bad Pig* was a reflection of this need to present only her likeable side. This story had come up as a result of Sally's drawing of a house, person and tree. I did not interpret these drawings in the standardized way, but rather in a more spontaneous way which resulted in making the connection between the story and the drawing of the house. My observation of this in connection with Sally's need to present herself well was that the way in which the character of the Pig turned from a malevolent one into a friendly one was the result of the wolves making their home likeable and beautiful. I wondered to what extent I was unconsciously colluding in Sally's efforts to be likeable and nice. I am sure that I was generous in my praise when she completed projects, and my needs and desires, both conscious and unconscious, for her to be whole and well were implicit in that praise. In addition, her abuse and neglect had been so horrific and ugly, and her present experience at home, at school, and in therapy contained nothing of that past ugliness, she may have felt reluctant to fully identify with this past.

It is unclear to me whether she ever realized how much I already knew about her. I had debated with my consultation group about whether to let her know that I knew about her history of abuse, and was generally advised to wait until she elicited the information herself since her ability to present herself to me in the way that she wanted me to see her may have represented part of the healing process. The most overt manifestation of her past horror was contained in her writing about the memory of eating a snake. I was concerned that my response to that writing, which in the moment I had attempted to keep very neutral, had in some way reinforced Sally's need to keep darker

memories and aspects of herself hidden. However, in retrospect, some of her most potent sand tray representations came following that disclosure, and were the ones with a focus on the heavily guarded treasure, giving rise eventually to the decorated treasure box.

The incident described earlier in which Sally imbued the bag of multi-colored goldfish crackers with the magic quality of being endless seemed to have resulted in a level of resolution. Although concerns around food continued, there was also a more playful quality to the way in which she addressed such concerns. Interestingly candy and chocolate were mentioned more frequently following this incident in contrast to the more sensible types of food, such as fruit and vegetables, which had occupied her previously. It seemed to me that some of the fear regarding the availability of food was alleviated by the idea that it could be provided by magic.

In terms of behaviors at home as reported by Lucy: Sally's mood and school performance both improved, and her daytime enuresis all but disappeared, although she continued to wet the bed at night. Although I did not observe any changes in Sally during sessions after she began taking SSRI antidepressants, Lucy reported that at home Sally and May's sibling conflicts diminished, there were fewer episodes of sexual acting out, and her peer relationships improved. Lucy attributed this in part to the effects of the medication. During my treatment of Sally, Lucy attended parenting classes at my suggestion with the result being that she felt more empowered and competent as a parent. Towards the end of treatment Lucy and I had a telephone conversation regarding some difficult behaviors of Sally's. I suggested to Lucy that Sally might be testing her commitment. Following this suggestion, there was a long pause in our conversation. Finally Lucy said, "I'm not giving her back!"

## **CHAPTER 4**

### **LEARNINGS**

#### **Key Concepts and Major Principles**

The key concepts and major principles discussed in this study contributed to my learnings about the topic and emanated from the literature related to complex trauma response resulting from chronic child abuse. As stated earlier, research has shown that children who have been exposed to chronic or ongoing abuse or neglect tend to experience complex symptoms above and beyond the symptoms experienced by individuals resulting from a single traumatic incident. Symptoms resulting from complex trauma have been noted to include affect regulation and impulse control problems, as well as problems with interpersonal relationships

Maltreatment by primary caregivers who are responsible for one's well being at a stage in life during which one is wholly dependent is an unthinkable paradox. Mills discussed the results of this paradoxical position in his observations regarding how child abuse can affect its victims sense of themselves.<sup>1</sup> Mills refers to the results of child abuse on its victims personality development as a "damaged core, dislocated and polluted." Such core damage limits psychic resources leading to profound problems in affect regulation. This observation seemed to me to serve as a description for the cause of Sally's tantrums and anger management problems. Bowlby's attachment theories are essential for understanding the way in which this paradox causes such profound damage.<sup>2</sup> Bowlby writes that the reason for such damage is the result of the overwhelming impulse

of a child to attach to their primary caregiver(s), likely to be their parents. This impulse, he asserts, subsumes all others. I make the assumption from this information that an abused child will attempt to attach to a caregiver no matter how heinous that caregiver's behavior is. In the event that it is impossible, the child experiences profound interruptions in their emotional and personality growth. Winnicott's points out in his discussion of the importance of a good enough mother how this may occur.<sup>3</sup> Winnicott writes that it is impossible for an infant to grow developmentally unless there is an attachment figure who begins by adapting to an infant's needs at first completely, and then less and less "according to the infant's growing ability to deal with her failure." It is the lack of these mitigating factors in cases of child abuse which leads to what J. Herman describes as the "forming and deforming the personality of a child."<sup>4</sup> Since Sally's abuse occurred during her early years when these developmental changes were in progress, she was vulnerable to such interruption in emotional growth.

A. Freud's theories regarding the primitive defenses that form at the time of trauma as a protection of an individual's sense of their core self remaining in place well after the trauma has disappeared also informed my understanding of what was happening for my client.<sup>5</sup> Winnicott expounds on this notion, noting that the instinct to develop such strong defenses is the result of an individual's perception that a violation of the inner core of their personality that they experience as self is unthinkable.<sup>6</sup> Related to this is Kalsched's idea of the persecutor/protector figure as a manifestation of the defenses which guard an individual's essential self.<sup>7</sup> Kalsched described the process of the structure of these defenses by suggesting that for victims of childhood trauma, typically one part of their personality regresses to an infantile period, and one part progresses, or



grows up, too fast and then attempts to caretake the regressed part. Kalsched has referred to this as “The Psyche’s archetypal healthcare system.”

During my work with Sally I came to understand more deeply the importance of the therapeutic alliance, in this case in particular, and for treating abused children in general. J. Herman writes about this noting that “the core experience of psychological trauma, such as child maltreatment, is disconnection from others.”<sup>9</sup> Recovery, she writes, can only take place within the context of a relationship, not in isolation. A survivor of such trauma needs to repair their capacity for “trust, autonomy, initiative, identity, and intimacy.” J. Herman asserts that since such competencies were damaged within a relationship, they can only be healed within a relationship. Edinger discusses this point from an archetypal perspective using alchemical imagery.<sup>10</sup> He, too, stresses that healing from childhood trauma must occur within a relationship, and suggests that it has the potential to occur within a therapeutic relationship. When a child is prevented from having an adequate relationship with a primary caregiver, perhaps as a result of maltreatment by that caregiver, Edinger argues that there is a gap in the child’s psychic landscape in which an essential archetypal image has not been personalized leaving children with a deficit within their personality structure. He relates this to the alchemical stage of coagulation, where more ethereal substances are made solid, noting that this is the developmental stage when external relationships are internalized within the psyche. Edinger contends that if children fail to accomplish coagulation with their primary caregiver, or achieve negative coagulation as a result of childhood abuse, aspects which have been coagulated in negative or traumatic ways will have to be broken up “and reoagulated under more favorable circumstances, perhaps in a therapeutic situation.”

This is an apt description of my work with Sally, and it is with such thoughts in mind that I nurtured and protected the predictability and safety of our psychotherapeutic relationship.

As noted earlier, the concept of imaginal structures provides a way to describe the way in which an abused child's view of the world is distorted. The trauma of abuse influences every facet of a child's experience, interactions, perceptions, sensory experience, and understanding. Omer has referred to imaginal structures as the clay which shapes experience; for the maltreated child every aspect of their experience is shaped by their maltreatment.<sup>10</sup>

In terms of understanding what can facilitate healing, the awakening and use of imagination is stressed. Omer has described imagination as the means of soulful expression.<sup>11</sup> Winnicott has called it essential for healing, and differentiated it from fantasy.<sup>12</sup> In order to awaken imagination in traumatized children play therapy has been recommended and used by numerous researchers and practitioners cited previously. A. Freud writes that through toys and play, "the child who is still limited in verbal skills, is able to create an environment in his own way."<sup>13</sup> Gil notes that play is the natural approach in working with children since it is the medium for children's self expression. Play allows for the release of a child's feelings while allowing an adult a window through which to observe a child's world.<sup>14</sup> Sally certainly utilized her imagination during therapy in the way described, and it has resulted in healing for her.

## What Happened

Everything that happened did so within the context of the relationship between Sally and I, and the building, testing, rupturing and repairing of our relationship was a major component of the therapy. The relationship itself had a personality that grew and developed organically during the course of our therapy journey; my task was to welcome every aspect of it allowing it to develop according to its own intrinsic nature. The very room in which the therapy took place informed the nature of the relationship, and thus was part of the relationship. For example, I mentioned earlier the way in which the windows were designed allowed us to see out while not allowing the people on the street outside to see in, thus creating the sense that this room was a very private space for Sally and I to inhabit and remain safe in while Sally shared her inner world with me. Sally reported that on several occasions when she was driven home by Lucy she would look back at the outside of the windows trying to see in, just to be sure that no one could. These comments from Sally reinforced for me the importance of protecting and nurturing the inviolate nature of our therapy space. The nurturance of the relationship in this way resulted in Sally and I becoming increasingly important to each other. Sally confirmed this for me by asking me questions to ensure that I remembered the things that she had told me, like the names of friends or the dates of important events.

It seemed to me that the heart of our therapeutic journey revolved around an exploration of the mother/child relationship including the yearning for, and ambivalence about this relationship within the context of Sally's life, and that our relationship contained refracting mirrors for this relationship. There were multiple references to this exploration over the course of treatment. The "Find the Fox" story involved the

mother/child relationship becoming ruptured and then repaired. The mother/child relationship was also represented in “The Story of the Fairy Princess” with reference to the potential pain it could cause by Sally’s choice of stickers with animal mother/child pairings in order to represent a dangerous mountain lion, even when there was a sticker of a mountain lion readily available which would have provided a much more literal image. The poignant finish to that story gave insight into Sally’s ambivalent feelings: “And the Fairy Princess becomes queen because she did a good job by herself without her mom and dad, and she and her friends live happily ever after, even the lion.”

The making of Sally’s Treasure Chest was a pivotal occurrence in our therapy journey allowing me further insight into Sally’s inner world. While the archetypal imagery present in it was unmistakable and alerted me to the primary myth providing the backdrop to our story as I will describe later, it also provided a window through which I could discern Sally’s defense of her fragile and wounded self. The Treasure Chest idea itself had been inspired by Sally’s sand trays. It represented a recurring theme involving precious treasure of some sort heavily guarded against malevolent entities trying to steal it. For instance, at one point in a sand tray Sally placed the chest between two ibis birds, which she told me were poisonous. On another occasion a figure of Godzilla provided protection. When I suggested that we decorate the bigger chest, my hope had been to get an idea of what it might contain that needed such safeguarding. What I noticed in the decorating of the larger chest was that the outside was decorated with playful animals, also of a representation of herself in costume, not her real self. The images inside were softer and more poignant, with multiple mother/child animal pairings. Again I had a sense of the significance of the mother/child relationship for Sally as one that was

precious, but represented a multitude of strong and difficult feelings needing containment within a chest that is guarded from outside predators. As I mentioned, this was one of the very few creations that Sally made during therapy that she wanted me to hold for her.

The therapy sessions during which we made the chest occurred at the time when Sally was beginning to refer to Lucy as “Mom”. This shift for Sally probably opened her up to some feelings of vulnerability and likely informed how she made this chest, my intuition told me that this was why the chest was so deeply guarded. In spite of the way in which Sally was opening up to the possibility of accepting Lucy as her mother, the archetypal representation of the mother/child relationship with its dark memories and potential to hurt was still better contained and guarded by poisonous birds, by Godzilla, and by me. Perhaps when Sally noticed that the shellac made the treasure chest smelled of wine there was some unconscious recognition by her that we had a shared history involving mothers whom we were separated from by substance abuse, or perhaps I unconsciously gave her that message myself. The painting of the shellac was a way of keeping the entire picture intact; the preciousness of the relationship, the way in which it must stay hidden and protected from the world, and its intrinsic dark nature. The fact that this project was followed by Sally making her broken-heart box at her strong urging was further information as to what was contained in the chest so heavily guarded. The theme of something precious contained within something else also repeated itself in that box since when she said that she wanted to take it home it was in order to keep her precious things inside it.

Throughout the course of therapy Sally led the journey where it needed to go. Sally’s enthusiasm for therapy, and the way in which many of the things that she did

during sessions made her seem so hungry for healing, engendered in me a feeling of urgency to walk her through the steps that I hoped would repair her brokenness. My consultation group was key in helping me to keep my own agenda at bay. There were times when it was obvious to me that Sally should be our guide, and my intuition allowed her the freedom to do just that. For instance, when May had to come into our session and Sally directed me to take care of her while she took care of the session, or when Sally wanted to dictate a story to me. However, there were other times when it was not so obvious, such as when she came in following a tantrum and just wanted the comfort of a story being read to her, or following the disclosure of the eating of the snake and she wanted to play a game. Yet in those moments I was able to contain my anxiety and impulse to protect her, and continue to provide her the opportunity to show me what she needed.

Inherent in Sally's tacit messages to me was that she wanted our therapy space to remain a place where she could present herself in her best light, and that she was distancing herself in an unconscious way from some of the horrific themes which were revealing themselves. I had the sense that Sally needed to feel a strong, positive foothold in her present experience before she could allow herself a more direct experience of the consequences of this horror. Again, my consultation group provided assistance in assuring me of the wisdom of Sally's unconscious, and the importance of allowing things to unfold at the pace of Sally's choosing. With all of these creations, Sally either directed me to help her or welcomed me as a witness to her process. As a result, she was no longer alone in her experience and my presence there, particularly since I was someone she had come to trust, was also healing.

## Imaginal Structures

### How I was Affected

As I have noted, losing my mother in the way that I did, first to mental illness, then to alcoholism, left me with a complicated grief within which lay a sense of yearning without hope of fulfillment. I understood that yearning as a type of broken heartedness, and it is this broken heartedness in me which resonated with Sally's experience. The final wording of Sally's Fairy Princess story in which she congratulates herself for doing a "good job...without her Mom and Dad" in particular evoked this sense of yearning and put me in touch with my own early memories of feeling alone when very young since I could not always rely on my mother's availability.

Sally's story was particularly horrific, and what actually happened in terms of the abuse and neglect is unthinkable. What made Sally's experience even more difficult to conceptualize is that the perpetrators were the very people who most in the world should have been protecting her against such horror. The depth of betrayal inherent in that circumstance was most difficult to consider. This paradox was represented in her treasure chest creation which represented something treasured beyond measure, yet dangerous enough that it must be guarded against. Considering this impossible conundrum put me in touch with a sense of madness. Within the puzzle of Sally's relationship with her early caregivers there was no possible resolution. For Sally, in those early years going away from her abusive caregivers who were also her source of food and shelter may have meant physical death, and going towards them emotional death. The betrayal inherent in being put in this situation was inconceivable.

Considering Sally's story reminded me of my feelings of betrayal during the time my mother became ill and before she died and the confusion that I felt related to the paradox that potentially she could have been present since she was still living, but actually it was not possible for her to do so because of her own internal strife. After her death, as I worked through my own grief, my understanding of mental illness and substance abuse assisted with my resolution of this sense of betrayal and I experienced an awakening of compassion for my mother. There was a way in which I could deal with the madness of the depth of the betrayal by understanding that this was not something done to me, it was simply the nature of things brought about by the paradox in which my mother found herself. What made this betrayal more poignant for me to consider was the realization that my mother actually yearned for me as much as I yearned for her. After she died I went to her house to sort through her possessions. I had not been there for seven years, and was surprised to find pictures of myself and my sister everywhere. She must have thought of us all the time and yet the circumstances of her own fight with madness kept us apart. Sally was also betrayed by a living mother, as well as a living father, people who had the potential to be there for her, but whose inner demons wouldn't let them. While finding ways to live with such betrayal may take the better part of a lifetime, and stages of healing from the trauma and grief are different at different developmental levels, I felt that the resonance of Sally's story as it came into contact with my own manifested in all kinds of unconscious ways throughout our therapy journey, and our relationship potentiated healing just by its very existence.



## **My Imaginal Structures**

My own imaginal structures were shaped by my grief for my mother. Also affecting my therapy with Sally and coloring the lenses with which I view things, was my ongoing ambivalent relationship with that grief. Over the years I made attempts to distance myself from it by: ignoring it, minimizing it, and explaining it in dry clinical terms. It seemed to me that the times when my therapy with Sally felt particularly engaged correlated with times when I felt unflinchingly in touch with the sense of broken heartedness which I referred to earlier. It is within the context of relationships that this imaginal structure is apparent. When I am connected with the yearning facet of it, I am also attuned to the quality of connectedness between people and what is occurring in the intersubjective field of a therapeutic relationship. When I distance myself from it, I also distance myself from all relationships. It was the yearning quality of this imaginal structure which informed my therapeutic relationship with Sally.

The facets of this imaginal structure contain refracting surfaces of the outrage of the betrayal, as well as the awareness of its inherent broken heartedness. When I noticed myself approaching my work with Sally from the felt perception of my own experience of betrayal and outrage, I found myself colluding with her anger. When I was more in touch with the facet of broken heartedness which was at the core of the anger, I noticed a greater tendency for archetypal imagery to appear. Embedded in this imaginal structure is a judging element; what happened to Sally in the past is wrong, and what is happening now is right. Viewed through the lens of this facet of my imaginal structure I saw Sally's situation as representative of social justice issues and found myself wanting to be a savior for Sally, and by extension the world. This imaginal structure would impel me to cloak

myself in my professionalism in order to be able to make speeches regarding the wrongness of child maltreatment, and anything else I could think of. Needless to say, such an approach was full of disconnection rather than connection, and fell flat in therapy since its tendency to group things into black and white issues provided a way to distance myself from the feelings and experiences inherent in the therapy.

### **The Client's Imaginal Structures**

Sally's primary imaginal structures were formed as a result of her earlier experience and she viewed the world through the lens of a complex trauma survivor whose trauma occurred at the hands of her primary caregivers. Resulting from that imaginal structure was sense of vigilance that kept a watch for danger. Also, a guarded quality, as evidenced in her sand trays with the fierce miniatures guarding what was precious to her. Sally's capacity for trust was compromised by this imaginal structure and it was no surprise that much of our therapy journey involved testing the trustworthiness of the therapeutic relationship and its container. Within this imaginal structure, Sally's perceptions were colored by her betrayal of the mother/child relationship and the yearning for that quality of connection. As Sally regarded her world and her relationships, she gauged them for the potential of assuaging some of the longings inherent in her imaginal structure. This betrayal also informed her anger, and her experience of being ignored and feeling unsafe at the hands of her primary caregiver was reflected in her conflicts with her peers. The echoes of this reverberated in her tantrums. I understood Sally's behaviors of hoarding and gorging food to be a manifestation of this

imaginal structure; that the world could not be relied upon to provide basic sustenance so Sally must find it herself, and hang on to it tightly.

Also informing Sally's imaginal structures was her history of being rejected by her biological parents, and enduring several foster care placements before being placed in Lucy's home. Sally's drawing of a house with its relevance to the story of the *Three Little Wolves* provided an image that was helpful in understanding the imaginal structure born of such a history; in order to be accepted and loved it is necessary to present oneself in the most beautiful way possible. While the story as it is written implies that such presentation engenders love and fulfillment, a darker interpretation can be made; that in order to receive love one must hide parts of oneself that may not be likeable, presenting only what is acceptable. This notion was reflected in Sally's treasure chest with its friendly, happy, playful images on the outside and its more vulnerable ones safely hidden within.

Inherent in this history of rejection is the imaginal structure related to broken heartedness that is also inherent in my own imaginal structures. It was the core of all of Sally's imaginal structures, as it is the core of mine. Within it lie all of the yearnings related to the mother/child relationship. Its existence was evidenced by Sally's drive to make something heart-shaped following the creation of her treasure chest. The connection between our imaginal structures and the recognition of each for the other resonated throughout the therapy. It was in this context that there was awareness that Sally and I mattered to each other, and it was in this sense of meaning something to each other that healing could occur. It may be that Sally's need for me to care for her

shellac/wine-smelling treasure chest was an acknowledgement of our interconnectedness embedded in my metaphorically holding for her our mutual broken hearts.

### **New Learnings About My Imaginal Structures**

During the writing of this paper I had a dream which continued to resonate for me and throw fresh light on my imaginal structures and the way in which I brought them into this therapeutic relationship. In the dream I was functioning in the capacity of a professional, perhaps a social worker. I was working with some parents who had twin boys who seemed to be about nine or 10. One of the twins, who was much shorter than I, suddenly squashed a large blob of soft butter on the top of my head. Sternly, I said to his parents, “You must consequence him.” The other twin took my hand, and together we walked up a nearby hill with a somewhat self righteous attitude knowing that there was a water source at the top, and this twin would wash the butter out of my hair. As we were walking I had the realization that this boy was too small and would not be able to reach my head.

Embedded in this dream is layer upon layer of mythopoetic meaning for me. The twins and Sally are around the same age that I was when my mother began to deteriorate. I personally relate the top of my head to be symbolic of my connection with the divine, or the numinous. One half of the twins, representing my own psyche as awakened by my work with Sally, clogs this connection up with butter, which I understand to be congealed mother’s milk. This either separates me from the divine, or illustrates that such a connection necessitates the messiness of human relationships and the grief and love of the mother/child archetype. In my dream I assume a professional role in order to distance

myself from this messiness. As I walk off up the hill with the second twin, I realize that he will not be able to restore my dignity and my professional capacity cannot help me. This messiness is essential, and is a metaphor for the profound nature of relationships without which the numinous cannot be touched.

This is my current interpretation of this dream; however I continue to work with it as it is very resonant for me and illuminative of the imaginal structures that I bring to therapy. It is somewhat difficult to describe them definitively since they are dynamic, always changing and unfolding. They were affected by the therapy, and the therapy affected them. It is my opinion that this synergistic relationship was essential and fundamental to the therapeutic process. If Sally had not mattered to me, and I was not affected by my work with her, I think our work would have been superficial and would not have resulted in any healing. On the other hand, if I had not continually remained conscious of such countertransference, therapy may have been ineffective or even destructive. While there may be some who caution that psychotherapists need to avoid having their own needs met by the client, I feel that it is necessary to have some of one's own needs involved in order to be moved by the client's experience, but always in conscious way, and always with the client's best interests in mind.

A feature of this intersubjective therapeutic connection with Sally was a sense that I was not entirely in control of the direction that the therapy was going; rather I came to believe that the relationship between us, and the therapeutic journey itself, had a personality and will of its own and that my job was to allow this process to occur safely for Sally. While I was not seeking such control, and was in fact encouraging the organic nature of our work, my countertransference reaction was to worry that I was not adequate

for the task. On several occasions, awed by archetypal symbolism and unconscious material appearing almost magically in our work, I would worry that I was not a skilled enough therapist to recognize and work with these significant moments. I think that these humbling doubts had the potential to convince me to step metaphorically out of the way and let the therapy occur. I am reminded of my dream symbolism, where I receive the knob of butter which confuses my connection with the divine, but is somehow necessary in order to reach the divine.

In the writing of this Case Study, and reflecting on my own imaginal structures juxtaposed with Sally's, I realized how much unconscious recognitions of each for the other provided a back drop for deep healing and for strengthening and informing the nature of our relationship. In all of those moments, when Sally did or said something and had the realization that I understood what she meant, I believe that she had a felt sense of my imaginal structures and my resulting capacity for holding and transcending her experience.

### **Primary Myth**

After Sally made her treasure chest, replete with its seasons on the four sides, and containing within it the image of the mother deer with a fawn stuck onto a picture of a half-pomegranate open with seeds revealed, I took it to my consultation group. Immediately my wise consultation group leader, Laura Doty, recognized the myth of Persephone and Demeter embedded in the decorations of the chest, and resonating in Sally's story.<sup>15</sup> Prodow and Cooney describe this myth in the following way: Persephone is the beloved daughter of Demeter "the goddess who turns the seasons and bestows the

life-giving fruits of harvest on mortals.”<sup>16</sup> Zeus, king of gods and mortals, is her father. While out gathering flowers one day with her friends, Persephone is taken by Hades, god of the dead and of the Underworld. Zeus has apparently promised Persephone to Hades as his wife, and Hades has fallen in love with Persephone. Demeter, upon finding that her daughter is missing, becomes frantic. The only witnesses to Persephone being taken to the underworld are Hecate, Goddess of the Moon, and Helios, God of the Sun, who both tell Demeter what has befallen her daughter. In her anguish at losing her daughter, Demeter ceases to allow the seasons to happen, confining the earth to harvestless winter. Persephone, in the underworld with Hades, is mourning her mother as much as her mother is mourning her. Zeus finally bows to Demeter’s pressure, and allows her to recover Persephone, but only if Persephone has not eaten anything while in the Underworld. Persephone, tempted by Hades, has eaten six pomegranate seeds. As a result, she must continue to spend one third of the year in the Underworld. Demeter promises to allow fruitful seasons to return to mortals while Persephone is with her, but promises only winter for the time that Persephone must return to the Underworld.

The archetypal imagery present on Sally’s treasure chest was poignant and magical. While the outside of the treasure chest was decorated with blooming flowers, the inside contained metaphors of mother child relationships with a pomegranate as a backdrop. The echoes of the myth of Persephone and Demeter resounded in Sally’s story, and the representation of it in her treasure chest was profound. In recognizing this association, I came to understand that the theme of our therapy was embedded in the story of a child’s yearning for her mother, and a mother’s yearning for her child.

The character of Demeter is described by Day as Mother Earth, sometimes known as Gaia.<sup>17</sup> Day writes that Demeter/Gaia's mythic task involved ensuring that the seasons happened as they should so that crops could grow in order to feed the population of mortals. Day notes that corn was the staple food of ancient Greece, and it was largely the continuation of the life cycle of corn that Demeter/Gaia was responsible for. The provision of food in order to sustain life is related to emotional nurturance and to mothering, since emotional and physical sustenance occur on a continuum, with both often provided by mothers

Some months after Sally's adoption by Lucy, Sally began calling Lucy "Mom," and clearly they each have an abiding love for each other. Yet in spite of Sally having found a mother with a deep and unconditional commitment to her she was compelled, like Persephone, by her circumstances to return at times to her own underworld of nightmares and the unrelinquishing grief representative of her early years of trauma. At other times, like Persephone returning to Demeter in the spring, she participated in family outings, got to know her various adoptive relations, and enjoyed being an integral part of her new-found family. The felt sense of standing consciously in the center of this story is illustrated in Doris Orgel's description of the ancient greek goddess Leto, whose mother is Pheobe, the goddess of the moon. Thinking that she glimpses her yearned for mother sitting on the moon, Leto cries out to her grandmother for her mother, saying that she misses her mother. Leto's grandmother reassures her, saying that her mother is with her always, "Inside the circle...of mothers and daughters...which is all around, always."



## Personal and Professional Development

As a result of working with this client and the process of writing this Clinical Case Study, I found myself much more aware of how my imaginal structures are present in every nuanced interaction. From my choice of activities, to my choice of words, they make themselves felt. It is for this reason that my continued examination of their nature is crucial since they have the potential for great damage, as well as great healing. As with every psychological exploration, it is a dynamic process lasting a lifetime. However, it is my opinion that I can read every theoretical book ever written, and attempt to apply its precepts, but it is my underlying imaginal structures which will truly guide my work. In my work with Sally, it was where our imaginal structures intersected that important shifts in therapy happened, and it was my tracking of my own feelings and reactions which were the clues as to the nature of those shifts.

Another important insight has been to consider relationships themselves as having their own lives, personalities and archetypal resonance. In this respect I am thinking about the relationship between Sally and I, and noticing that its organic nature was not particularly in my control. Another example of a relationship with its own personality was represented in Sally's attempts to personify and consider the mother/child relationship in the way that she did by utilizing the metaphors that I have described. In my thinking regarding this phenomenon I feel more in touch with a perception that all experience is dynamic and fluid.

In terms of professional development I find that my knowledge of play therapy, in particular sand tray, is greatly enhanced. The therapy with Sally would have taken an entirely different course without the use of sand tray. While I have utilized it most

helpfully for many years prior to the writing of this Clinical Case Study, this was the most profound experience in terms of watching archetypal images emerge and take shape out of the therapy, providing a way for me to share with Sally her inner experience using the language of the soul. The practical knowledge and information regarding research on victims of complex trauma provided a template for the archetypal experience, and vice versa.

### **Applying an Imaginal Approach to Psychotherapy**

While it has been my experience that an imaginal approach to psychotherapy is related to a psychodynamic theory, and the orientation of the Children's Therapy Project is not antithetical to imaginal concepts, I notice it is the imaginal approach to psychotherapy which supplied the container for my treatment of Sally, and without it my work would have lacked a necessary depth. As a result, I have been able to remain aware of a larger perspective which includes the idea that I am not just working to alleviate Sally's symptoms, but also to connect us both to the greater story of human experience which includes our mutual ancestors and archetypal resonances, and thus back to each other. Embedded in this idea is the notion that Sally and I were each affected by each other, and our mutual intersubjectivity was an intrinsic part of the therapy informing the way in which we built and maintained our relationship and nurtured its synergy.

An example of working in an imaginal way which provided a connection to a greater, archetypal experience is when Sally mythologized her experience by writing her story, "The Story of the Fairy Pressess." Her tale, and its illustrations emanating from her experience contained layer upon layer of resonant meaning and the writing of the story

brought a new dimension of understanding to our therapy. The making of Sally's treasure chest and broken-heart box had the same effect. Also related to the notion of the application of an imaginal approach to psychotherapy, is the recognition of the myth guiding that particular psychotherapeutic experience. By considering the myth of Demeter and Persephone to be the primary myth in Sally's case there was access to much deeper meaning. In addition, the mythological nature of such understanding means that the therapy was not a finite answer to a specific question rather it accessed a kind of essence, in this case relating to the nature of mother/child relationships.

## CHAPTER 5

### REFLECTIONS

#### **Personal Development and Transformation**

The writing of this Case Study has directed me to consider more deeply the archetypal forces which guide and hold my work. This consideration has raised my awareness regarding the issues and situations that I cannot control, specifically in the context of my work with Sally the fact that I could not alter the archetypal backdrops against which our mutual dramas took place. In general, my task as a psychotherapist is to provide the conduit for the connection to these stories in order to facilitate healing. As a result of these insights, I have experienced my therapy practice deepening exponentially. Embedded within this recognition of the archetypal facet of my work is an ever growing understanding of my personal imaginal structures, and the ways in which they limit me by concealing underlying understanding and compassion.

In order to effectively treat Sally, I had to fully open myself up to my own grief, especially my grief for my mother. Up to this point, I had been able to some extent, to compartmentalize this grief within my psyche. In order for me to encourage Sally to work with her own grief I had to ever more completely acknowledge mine. The act of embracing and opening up to the deep sadness of losing my mother, and losing her in the way in which I did, enabled me to cease to engage in all kinds of habitual behaviors which had become part of my way of life in order to defend against such grief. Letting go of these defenses afforded me a more liberated and spontaneous capacity for experience.

Related to this newfound capacity for spontaneity resulting from turning towards my grief instead of turning away from it, I found a renewed potential for fearlessness in psychological situations. For instance, since Sally's early experiences were horrific in terms of what actually happened to her, such as her defenselessness as an infant and the cruelty with which the abuse was afflicted by adults who were supposed to be in charge of her well being, it would be easy to become overwhelmed by the nightmarish facts of Sally's situation and respond by trying to encourage her to try to forget that it happened, thus colluding in her psychological defensive process of encapsulating her experience. As a therapist I must meet and greet all aspects of individuals with whom I work, including their most disowned parts. My unconditional acceptance of all aspects of their psyche allows them to accept themselves; therefore I must be fearless in the psychological realms in which I accompany them.

### **Impact of the Learnings on My Understanding of the Topic**

While I don't think that my review of the literature regarding trauma significantly altered my initial understanding of the clinical topic, it broadened and deepened it, particularly in regard to complex trauma resulting from child abuse. From each perspective explored there is agreement about most of the common aspects of trauma experience, particularly the difference between a trauma response resulting from a single incident, and a response resulting from ongoing more complex traumatic experience such as child abuse. There is also agreement that for victims of childhood maltreatment there is often a lifelong vulnerability to become symptomatic following further trauma later in life. In addition, it has been noted that the children of those

individuals who suffered complex trauma remained vulnerable in the face of further trauma and were more likely to suffer pathology, strongly suggesting that PTSD is a generational issue. My learnings reinforce for me a further concern regarding PTSD resulting from the complex trauma of child maltreatment, which is that it involves symptoms which are not included in the DSM criteria list of symptoms for PTSD, and those symptoms may not be recognized as trauma responses. Thus complex PTSD in victims of child abuse has the potential to be misdiagnosed or unrecognized. I have seen evidence of this during my work with foster children who have been removed from their families because of maltreatment. These children often suffered from symptoms resulting from complex trauma and, as researchers have cautioned, the symptoms are frequently not recognized as such, but instead are labeled as problematic behaviors.

I found the discussion of the relationship between complex PTSD and attachment difficulties particularly illuminating. Studies have drawn attention to the idea that child maltreatment at the hands of a primary caregiver may represent a rupture in attachment to that caregiver. Authors cited note that the result of healthy attachment provides resilience to further trauma or other life difficulties, as well as skill in affect regulation. Connected to this discussion is the idea that maltreatment by a primary caregiver may create, for a child who is dependent on that caregiver, an impossible conundrum consisting of a paradox in which a child finds themselves terrorized by the very individual, or individuals, upon whom they rely for survival. The child in the midst of this paradox must suppress their individuality where it might put them at risk, and attune themselves to the moods and activities of that caregiver in order to attempt to have their survival needs, such as food and shelter, met with the minimum of abuse. In considering this I was

struck by the extent to which life and death issues have the potential to be part of the dilemma. Physical survival is often at stake, either because of lack of basic life sustaining necessities, or because of life threatening abuse. In addition, given the primacy of the need for attachment discussed earlier there is a type of psychological life and death at stake as well. Indeed, the work of Kalsched, Winnicott, and Tolpin suggest that the threat to a sense of self as may be experienced by a child who has had to suppress their identity in order to be safe from abuse, is unthinkable, with the resulting consequence of a type of personality fragmentation, or personality death.

I found these insights most helpful in terms of validating my emphasis on the profound importance of the quality of my relationship with Sally. By focusing on our relationship, the attachment issues and the trauma were addressed concurrently which was critical given their interrelatedness. Treating trauma with such an emphasis represents a deviation from the generally accepted treatment of single incident trauma which may be more amenable to treatments such as CBT techniques which simply target symptoms. In addition, the wide acceptance of CBT techniques to treat trauma resulting from child abuse, bolstered by numerous studies supporting the efficacy of such techniques, does not necessarily emphasize the relational component of treating PTSD resulting from child abuse.

### **Mythic Implications of the Learnings**

The ancient Greek myth of Demeter and Persephone provided a crucial backdrop to my work with Sally, and to the writing of this case study. Its refracting surfaces mirrored back my own grief, Sally's anguish, and informed the therapy journey. A

characteristic attributed to Demeter is that of a provider of sustenance, as well as mothering. This connection with nurturance and sustenance was primary in Sally's story, and evident throughout our therapeutic relationship. Having identified my imaginal structures as containing refractions of the mother/child relationship, the idea of sustenance, and emotional, physical, and spiritual nourishment feels central in my approach to my work, especially with Sally.

This myth is also useful for providing a mirror to describe the therapy process in general. Using Sally as an example, during my work with her it was my task to accompany her on her necessary journey, like Persephone, back to the Underworld of her past experience, and to explore it with her in order to help her try to find it less frightening. Many of the activities we did in the therapy room constituted ways to assist in this process. For instance, the way that we structured Sally's journal was reminiscent of Persephone's story; half of it to be spent in the sunlight writing about her current experiences with Lucy and her family, and half to be spent in the Underworld, remembering her life before. The therapy room and my relationship with my client can be thought of as being in the sunlight. From the safety of this relationship it was possible to slip down into her Underworld knowing that there would be a return back to the sunlight. Both worlds existed, and it was the capacity to move between them that provided the potential for growth.

### **Significance of the Learnings**

As I noted earlier, part of my motivation for this topic, and for my work in general is related to my experience working with children in foster care. As noted earlier, recognizing the implications of child maltreatment in terms of its traumatic impact on its



victims is only a few decades old. Since the potential for significant psychological damage from child abuse is so high, and profoundly impacts the life of the sufferer, it seems essential to understand its complexity more deeply.

My own learnings emphasize, and re-emphasize that healing from such trauma must occur within the context of valued relationships. In addition, current CBT therapies popularly studied are not sufficient in themselves but need a relational component in order to achieve success. Inherent in this relational approach is a need to take into account the nature of the potential damage resulting from child maltreatment which includes the idea that victims of such experience may repress their sense of their own identity in order to survive their abuse, resulting in potential for all types of life failures. Such therapy must occur in a consistent context in order for a trustworthy relationship to develop. Treatment approaches must take this into account, and allow for full expression of experience in order for individuals to reclaim their sense of self.

In terms of relating such expression to treating children, the importance of imagination as the underlying driver of expression cannot be underestimated. Play and art are a means of engaging imagination. Children may not have the verbal tools, or developmental sophistication necessary to engage in other kinds of therapy. In addition, imagination is the means by which therapy and healing can move into an archetypal landscape. Since the damage engendered by complex trauma includes the soul, it is only via the language of imagination its deep roots can be addressed.

As a result of my treatment journey with Sally, and the writing of this Clinical Case Study, I feel that I have an exponentially deepened sense of the importance of having a place in one's life where one is completely and unconditionally accepted for

simply being oneself. For abused children, or children in foster care, this insight is particularly poignant since they rarely have such a situation. While they are in the care of their abusers, they risk further maltreatment if they are not on constant alert for danger and must continually modify their behavior in order to mitigate such danger, thus they cannot express themselves spontaneously. If they are removed from their caregivers and placed in foster care they must also continually modify their behavior otherwise they risk rejection and removal from placement, again repressing spontaneity. For such a child in therapy, the therapeutic relationship then becomes all important as a place where they are accepted unconditionally, and encouraged and allowed to express any internal experience without restriction.

### **The Application of Imaginal Psychology to Psychotherapy**

Applying Imaginal Psychology to psychotherapy involves the utilization of mediums and activities which serve the purpose of awaking imagination so that psychological material may be accessed in symbolic, archetypal, and mythopoetic ways. In addition, I have found that working within the context of the Imaginal approach involves a recognition that the work of psychotherapists is connected with sacredness and has a relationship with the numinous. Such awareness prevents imagination becoming bogged down in interpretations which reduce, rather than expand experience. An imaginal approach to psychotherapy entails the notion that the purpose of the work is to assist an individual in embracing the whole of their experience, and connect that with the experiences of all humans. Mediums and activities with the capacity to move in this direction often include art, story writing, journaling, and sand tray. However, it is not the

medium itself but the way it is used which expands its refractive surface. The imaginal approach to psychology involves image-making and using such images as windows for understanding utilizing direct and immediate experience.

I have found mythologizing experience fundamental in moving a psychotherapy experience into an Imaginal dimension. Myths and mythopoetic experiences provide the link between the experience of the individual and the archetypal experience of the collective. An individual's recognition of such a mythic mirror of their experience provides a connection with the larger story, and with all human experience. Such connections are healing in and of themselves. Imagination, the creative arts, and story telling within the context of play are the natural languages of children who intuitively recognize and perform connections. This was evident with Sally, particularly in the making of her treasure chest. I did not share with her my recognition of the myth Demeter and Persephone following her completion of this creation, I simply asked her if she was aware of the story and she claimed that she was not. However, my own recognition of its connection with Sally's experience and with our work together, deepened our psychotherapy and my understandings of the overlapping connection of our imaginal structures.

Sally needed no prompting in order to encourage her to involve her imagination, including writing stories which mythologized her experience. My sense was that the imaginal realm was everywhere, and it would have been impossible to get her to work in any other way than imaginal. For children, Sally included, archetypes are all around and are all important. They are embodied in the characters in stories, and in movies, even in video games. When I consider how to utilize an imaginal approach to psychotherapy in

mainstream settings and clients, my first thought is that my therapeutic interventions are always informed by the individual who I am treating. In other words, if a client firmly believes that their dreams are simply a meaningless reaction to synaptic activity but they would like some cognitive/behavioral tools to assist them with anxiety management, I will begin by providing such tools rather than attempting to convince them of the usefulness of examining their dream imagery. While the imaginal approach informs my own thinking it does not exclude other approaches, and I do not feel a need to name psychological process in ways that a given client would not be ready to accept. However, I have often found ways to assist a client in identifying a mythic or archetypal facet to their story in ways which deepen their experience without further explanation. For instance, if clients find themselves in a complex life situation I might ask them what movie characters they remind themselves of, or what famous or fictional characters they would like to be, thus clients identify their experience in a mythic ways and link it to a story greater than themselves. In terms of bridging an imaginal approach to psychotherapeutic interventions in children, I have found it helpful to explain the concepts of Play Therapy to parents which involves a description of symbolic play including sand play and art therapy. The benefits of Play Therapy are well researched and documented. Generally this helps the most skeptical of parents accept the potential benefit of utilizing imagination in order to facilitate healing.

### **Bridging Imaginal Psychology**

Since the imaginal approach to psychology is inclusive rather than exclusive and embraces all other approaches, I have not found much difficulty in bridging the concepts

with other professionals and disciplines. I have found that one of the imperatives in being human is meaning-making, and the only way to engage in meaning-making is by utilizing imagination. Most clinicians from all disciplines if they engage in the practice of psychology with any depth find the same thing, and acknowledge that such meaning-making is key to healing. There are many parallel concepts contained within the language of Imaginal Psychology and the language of other disciplines, such as the notion of imaginal structures and the Cognitive Behavioral idea of schemas. Such parallel ideas assist in facilitating a natural bridge and provide a means of explanation. An understanding of the relationship between imagination and issues of the soul, or the numinous, can be a more difficult to explain to those who do not find it self-evident. However, particularly when considering my work with this clinical case study, as archetypal imagery becomes evident, so does the connection between psychology and a sense of sacredness.

### **Areas for Future Research**

The continuing discussion regarding the effects of ongoing, chronic child abuse on its victims remains an area for future research with particular attention to the child maltreatment and attachment problems. Inherent in this research are recommendations for treatment approaches which address the concurrent effects of trauma and abuse. For children such as Sally who have suffered trauma and are embarking on a journey with a new family, it would be helpful to have research regarding treatment approaches to assist in that family establishing bonds and attachments. Some of Sally's trauma results from witnessing May being sexually abused and neglected. Sally as the older sister often

responsible for caring for May was affected in a particular way, research regarding the experience of an older-caregiving sibling, and/or a sibling who witnessed the abuse of another sibling needs exploration. Further exploration of particular modalities of play therapy as they relate to the treatment of traumatized children is a continuing area of necessary research.

**APPENDIX**

## APPENDIX 1

### INFORMED CONSENT FORM

To “name of adoptive mother”

Your child is invited to be the subject of a Clinical Case Study on Post Traumatic Stress Disorder. The study’s purpose is to better understand this disorder, and to explore effective treatment options.

For the protection of your privacy and that of your child, all my notes will be kept confidential, and your identity will be protected. In the reporting of information in published material, any and all information that could serve to identify you will be altered to ensure your anonymity.

This study is of a research nature, and may offer no direct benefit to you. The published findings, however, may be useful to assist individuals who have been traumatized, and may provide a deeper understanding of Post Traumatic Stress Disorder.

The Clinical Case Study does not directly require your involvement. However, it is possible that simply knowing that your child is the subject of the study could affect you in ways which could distract you from your primary focus of using therapy to assist your child in coming to terms with her trauma, and successfully integrating into your family. If at any time you develop concerns or questions, I will make every effort to discuss these with you.

If you decide to participate in this Clinical Case Study, you may withdraw your consent and discontinue your participation at any time and for any reason. Please note as well that I may need to terminate your being the subject of the study at any point and for any reason; I will inform you of this change, should I need to make it.

If you have any questions or concerns, you may discuss these with me, or you may contact the Clinical Case Study Coordinator at the Institute of Imaginal Studies, 47 Sixth Street, Petaluma, CA 94952, telephone: (707) 765-1836.

I, name of adoptive mother, understand and consent for my child to be the subject of, or to be referred to in, the Clinical Case Study, written by Virginia Crossleysmith, on the topic of Post Traumatic Stress Disorder. I understand private and confidential information may be discussed or disclosed in this Clinical Case Study. I have had this study explained to me by Virginia Crossleysmith. Any questions of mine about this Clinical Case Study have been answered, and I have received a copy of this consent form. My participation in this study is entirely voluntary.



I knowingly and voluntarily give my unconditional consent for use of both my clinical case history, as well as for disclosure of all other information about me including, but not limited to, information which may be considered private or confidential. I understand that Virginia Crossleysmith will not disclose my name, or the names of any persons involved with me in this Clinical Case Study.

I hereby unconditionally forever release Virginia Crossleysmith and the Institute of Imaginal Studies (and all of its trustees, officers, employees, agents, faculty, successors, and assigns) from any and all claims, demands, and legal causes of action whether known or unknown, arising out of the mention, use and disclosure of my child's clinical case history, and all information concerning me include, but not limited to , information which may be considered private and confidential. The Institute of Imaginal Studies assumes no responsibility for any psychological injury that may result from this study.

The terms and provisions of this consent shall be binding upon my heirs, representatives, successors, and assigns. The terms and provisions of this consent shall be construed and interpreted pursuant to the lass of the State of California.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_ at \_\_\_\_\_

By: \_\_\_\_\_



**APPENDIX 3**

**SALLY'S TREASURE CHEST**

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Illustration 2a. The Inside of Sally's Treasure Chest

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Illustration 2b. The Top of Sally's Treasure Chest

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Illustration 2c. Bottom of the Treasure Chest

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Illustration 2d. Side of the Chest  
Representing Easter

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Illustration 2e. Side of the Chest  
Representing Christmas

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Illustration 2f. Side of the Chest  
Representing Sally's Birthday

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Illustration 2g. Side of the Chest  
Representing Halloween

**APPENDIX 4**

**SALLY'S ARTWORK**



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Illustration 3a. Tree



Illustration 3b. Person



Illustration 3c. House

**APPENDIX 5**

**SALLY'S STORY**

Illustration 4a. Cover of Sally's Story

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Illustration 4b. Story Page One

Illustration 4c. Story Page Two



Illustration 4d. Story Page Three

Illustration 4e. Story Page Four

**APPENDIX 6**

**SALLY'S DECORATED BOX**



Illustration 5. Sally's Broken Heart



## NOTES

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