CHAPTER 4

Developmental Transformations in the Treatment of Sexually Abused Children

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Introduction

Jamaar is an 8-year-old African-American boy referred by child protective services for a forensic evaluation of possible sexual abuse. Child protective services initially became involved with his family when Jamaar was 6. He was placed in foster care at age 7 because of parental neglect, substance abuse, domestic violence, and the family's failure to comply with services. When Jamaar was removed from his home, his biological parents did not seek further visitation or reunification, agreeing to terminate their parental rights without litigation. Unfortunately, caseworkers placed Jamaar in a foster home directly across the street from his biological parents and his 16-year-old paternal uncle. They explained the reasoning behind this decision was because of the difficulty of finding foster parents willing to take boys. After 1 year in foster placement, Jamaar disclosed sexual abuse by his 16-year-old uncle.

In order to protect Jamaar's confidentiality, all names used in this case study, including the foster mother's name, and other significant case details have been disguised. In this chapter, we will provide background information, the theoretical considerations for using developmental transformations for sexual abuse treatment and the case description of a 2-year therapy process.
Background Information
Shirley is an African-American who has been a foster mother for several years. Soon after Jamaar was placed with her, she became afraid of him. He was in fights three or four times a week while on the bus and in class. Some of the boys at school complained that Jamaar tried “sex stuff” with them in the bathroom. The school psychologist classified him as having low-average intelligence and emotional disturbance, and he was diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD). He urinated in his bed most nights and refused to sleep alone in his room. When Shirley woke to find Jamaar standing next to her bed staring at her, she began locking her bedroom door. She asked him why he refused to sleep in his room. He told her that “Chucky” was going to come in through the window and “stab me up with a knife.” Jamaar described how he saw “Chucky’s face coming through the mirror” in the bathroom.

During the year before his disclosure of sexual abuse, caseworkers took Jamaar to a psychiatrist who diagnosed him with a psychotic disorder (Not Otherwise Specified) and prescribed Haldol. He was referred for therapy. He refused to speak to the first therapist and treatment terminated. His aggression at school, nighttime waking, hypervigilance, and enuresis continued. Shirley took him to a second psychiatrist who diagnosed Jamaar with bipolar disorder and prescribed Risperidal and Depakote. He again refused to attend therapy.

Jamaar disclosed sexual abuse to Shirley. Shirley and Jamaar were watching a television show about a girl who was kidnapped. Jamaar became angry and told his foster mother that he used to play “naked games” with his uncle. He then began to cry. He did not describe further to her what happened with his uncle. His 16-year-old uncle was living in the home of his biological parents across the street from the foster home.

Jamaar told Shirley that he was afraid of his uncle and told her not to tell anyone about the “naked games.” Shirley called the caseworkers. Prosecutors were called. He received medical and forensic evaluations. His story was consistent in the main facts and in many of the peripheral details. Jamaar described ongoing sexual abuse that included forced oral and anal sex, the use of derogatory names, and threats to harm his family if he told anyone. Forensic evaluators clinically substantiated sexual, physical, and emotional abuse.

However, prosecutors decided not to take the case because there was no physical evidence. Even with this new disclosure of sexual abuse, child protective services felt there was no current risk and decided not to move Jamaar to a new foster home. Jamaar continued to live in a foster home across the street from his uncle and biological parents. He was referred a third time for treatment, this time for sexual abuse.

Theoretical Considerations
Child sexual abuse is any sexual activity with a child where consent is not or cannot be given (Cohen, Berliner, & March, 2000). Most child sexual abuse is not disclosed at the time it occurs (Finkelhor, Hotaling, Lewis, & Smith, 1990). Retrospective studies indicate that 20% to 25% of women and from 5% to 15% of men experience sexual abuse before eighteen years of age in the United States (Finkelhor, 1994).

Prospective longitudinal studies of adults with documented sexual abuse histories in childhood have found that more than 30% of respondents did not report sexual abuse experiences when questioned as adults (Widom & Morris, 1997). In addition, boys, more than girls, fail to disclose sexual abuse because of the stigma associated with sexual victimization (Finkelhor, 1993). For these reasons, and because most sexual abuse does not result in physical signs, it is probable that current figures underestimate the number of children who have been sexually abused (Smith et al., 2000).

Sexually victimized children have nearly a fourfold increased lifetime risk for developing psychiatric disorders and a threefold risk for substance abuse when compared to non-victimized children (Finkelhor & Dziuba-Leatherman, 1994; Kendall-Tackett, Williams, & Finkelhor, 1993; Pynoos, Steinberg, & Wraith, 1995). Cuffe and Prick-Helms (1995) note that 30% to 50% of sexually abused children meet full diagnostic criteria for Posttraumatic Stress Disorder (PTSD). Sexualized behavior and aggression are frequently associated outcomes from sexual abuse experiences (Berliner & Briere, 1997; Friedrich, 1992; McLeer, Deblinger, Henry, & Orvaschel, 1992). Misdiagnosis, failure to respond competently to disclosure, and lack of therapeutic intervention can result in adult psychopathology (Sroufe, 1989).

Child Traumatic Stress Studies
Child traumatic stress studies document how interactions with abusive caretakers may be associated with pathological changes in developing anatomical structures and physiology in the brain (Perry et al., 1995). Functioning of right brain limbic structures, such as the amygdala and hippocampus, that are associated with arousal, behavior, emotion, memory, and language have shown alterations in maltreated children (DeBellis et al., 1999; Garber & Dodge, 1991; LeDoux, 1996; Schore, 1994). Specifically, dysregulation of the hypothalamic-pituitary-adrenal axis has been suggested to be an important mediating pathway for the chronic, autonomic hyper-arousal and dissociation frequently observed in sexually abused children.

Psychological processes such as disembodiment (dissociation), conditioned fear (implicit memory), and cognitive distortion of schemas of self and other have been proposed as targets for intervention (Briere, 1992).
Theorists recommend that intervention strategies be designed that: (1) are embodied (behavioral); (2) access implicit memory; (3) modify distorted cognitive affective representations of self and others; and (4) include imaginal exposure for gradual desensitization (Greenberg & van der Kolk, 1989; James, 1994; Rothschild, 2000; Saigh, 1992; van der Kolk, 1994).

Experiences of child maltreatment disrupt the developmental self-experience of "embodiment" (Young, 1992). Embodiment is defined here as the felt sense of safety, control, and pleasure being in the body. Disembodiment (dissociation) is frequently associated with traumatic sexual experience (Putnam, 1990). Children "leave" their bodies during experiences of sexual abuse and when under stress. Alternating chronic hyper-arousal and dissociation can disrupt normal development within social and emotional developmental pathways.

Explicit memory systems allow for the verbal narration of events. Implicit memory is associated with attachment behaviors, non-verbal memory, sensory experience, and conditioned fear response (Schacter, 1996). It is suggested that memory for sexual abuse may be primarily encoded in sensory-motor and imagistic representation in implicit memory and not consciously available to children for verbal report. Fear conditioning may predispose the child to state-dependent and environmental reminders of abuse (triggers) resulting in PTSD symptoms of re-experiencing such as nightmares, flashbacks, and behavioral reenactments (March, Amaya-Jackson, & Pynoos, 1997).

The Creative Arts Therapies and Child Maltreatment

The creative arts therapies of art, music, dance, drama, and poetry have been used in the assessment and psychotherapy of all types of child maltreatment. These methods are embodied (behavioral) and can effectively access implicit memory in abused children (Cattanach, 1992; Cohen & Cox, 1995; Dayton, 1997; Golub, 1985; Kluft, 1992; Spring, 1993; Winn, 1994). The symbolic media of the creative arts therapies may provide more complete access to implicit memory than do primarily verbal approaches to treatment (Johnson, 2000). Creative arts therapies can invoke cues to kinesthetic and visual sensory memories related to child abuse experiences. These structured approaches can prevent emotional flooding (hyper-arousal) by providing the child a sense of control and emotional distance through the manipulation of symbolic art materials. Rather than dissociate to cope with traumatic memory, children can be taught to use the creative mediums to represent experiences that are beyond words.

Due to dissociation, abused children are often unable to attend to abstract verbal discussion regarding traumatic material. For instance, treatment guidelines for the International Society for the Study of Dissociation (1997) recommend the use of primarily non-verbal techniques such as the creative arts therapies to access dissociated (implicit) traumatic memory. Research studies conducted with adult Vietnam combat veterans diagnosed with PTSD and alexithymia (inability to put feelings into words) documented greater treatment effect sizes when primarily action oriented creative arts therapies were compared to verbal therapeutic approaches (Johnson et al., 1997; Morgan & Johnson, 1995). Currently, psychodynamic play therapy, creative arts therapies, and cognitive behavioral approaches are used extensively in the treatment of child maltreatment. Unfortunately, to date, no treatment outcome studies have been conducted comparing these approaches in their effectiveness (Deblinger & Heflin, 1996).

Because of the wide range of symbolic media used in the arts, creative arts therapists can engage children at different cognitive developmental levels. Observers of cognitive development have often noted that representation of internal affective states proceeds through three stages of development: sensory-motor (music, dance, drama), symbolic (art), and lexical (poetry) (Bruner, 1964; Flavell, Miller, & Miller, 1993; Piaget, 1951; Werner & Kaplan, 1963). Through repeated interactions with emotionally attuned caregivers, children gradually learn to modulate the intensity of physiologic arousal and to translate affective states into forms of kinesthetic and imagistic representation of self and others in action (Lane & Schwartz, 1987; Stern, 1985). This cognitive developmental process is the interpersonal context in which the child develops internalized representations of self and others. Maltreatment disrupts this healthy developmental pathway.

Child maltreatment can create abuse-related internalized working models of self and others (Alexander, 1992; Bowlby, 1969). Negative expectations of intimate relationships based on a history of sexual abuse can distort perceptions of non-abusive others (McCann, Pearlman, Sakheim, & Abrahamson, 1988). Sexually abused children frequently present as emotionally distant, distrustful, aggressive, and hyper-vigilant due to their expectations of being abused by others. Internalized shame, diminished capacity for empathy, and identification with an aggressor are common outcomes in sexually abused children (Lewis & Haviland-Jones, 2000).

Developmental Transformations in the Treatment of Sexual Abuse

The capacity for imaginative play and the risk factors that distort this process are important indicators of psychopathology in children (Fonagy & Target, 1996; Slade & Wolf, 1994; Tetz, 1994). Harris (2000), in his review of
the research on children’s imaginative play, privileges interpersonal discrepant play (co-created role-playing) over solitary object play (projective techniques, toys, games) as the primary pathway for overall cognitive development, including the capacity to differentiate between fantasy and reality and the development of social perspective taking (theory of mind). Drama therapy may be particularly useful for accessing internalized representations of self and others in action. Drama therapy can access in imaginative play with sexually abused children the vulnerable self and the perpetrating other for cognitive restructuring.

Developmental Transformations is an improvisational drama therapy method that privileges the embodied interpersonal encounter between the therapist and the sexually abused child. Therapists using Developmental Transformations engage the child in a healthy cognitive developmental process that is experienced as pleasurable by the child. Projective objects such as toys, masks, or puppets are removed from the playroom in order for the therapist to function as the “embodied play object” and maximize the interpersonal focus of the therapeutic process. The therapist using Developmental Transformations provides for an “emotional prosthesis” by re-engaging the sexually abused child in an embodied process for translating affective arousal into imaginative representations during the improvisational play. This process is intended to reduce arousal and increase a sense of safety and competency in affective regulation for the child.

Experiences Beyond Words

The therapist, fully aware of the child’s specific sexual abuse disclosure (exact words and bodily experiences), allows the known abuse history to inform their improvisational responses to the child. The therapist follows and embodies the child’s indications of abuse-related symbolic material during the improvisation. The therapist follows the cues given by the child in the course of play and does not introduce the abuse material directly to the child without indications that the child feels safe to represent the trauma story. Our experience is that, unlike using models of therapy that introduce the abuse material in a predetermined phase of treatment, in this method, the child produces trauma material as they feel safe in the relationship with a particular therapist and, comparatively, in a relatively early phase of treatment.

In approaching sexual abuse-related material, therapists using Developmental Transformations do not privilege abstract verbal expression alone. Linking initially with the child’s primary expressive language such as movement, images, or words (as privileged by the child) provides diagnostic information regarding cognitive and language deficits due to abuse experiences while allowing the child to control the choice of the symbolic language for the therapy. The unique power structure provides the sexually abused child with a significant incentive to engage with the therapist using Developmental Transformations. Observed inhibitions in the child’s freedom to imaginatively play and the controlling or repetitive play style often observed in sexually abused children are understood as emerging abuse-related personifications and abuse contexts, and are indicative of the affects of rage, shame, and loss (James & Johnson, 1996). The emergence of traumatic material and possible confusion between fantasy and reality obviously constrains the capacity to play in the child. Our experience has been that abuse material evidenced by constrained play emerges relatively early in therapy using Developmental Transformations, thus allowing the therapist to intervene from within the ongoing improvisational play for the purpose of reassuring the child and maintaining the conditions of the play space.

The therapist intervenes primarily from within the play space (Johnson, 1992), the therapeutic container or transitional space for the embodied encounter between the therapist and child (Johnson, 2000; Winnicott, 1953). The primary intervention by the therapist using Developmental Transformations is to engage the resilient aspects of the child self and the abuse-related material from within the play space. Three ethical conditions need to be present in order to establish the play space: mutual agreement (between child and therapist), discrepancy (knowing this is pretend), and restraint against harm (defined boundaries between representation of aggression/sexuality and reality). The therapist models for the child how to embody the flow of images, thoughts, feelings, roles, gestures, movements, impulses, and silences emerging during an extended improvisational play. The therapist notices the child’s verbal and non-verbal behavior and embodies material that appears meaningful for the child. Meaning is evident in the child’s behavior by increased energy (spontaneity) that indicates the child feels safe with particular themes and roles being represented. The therapist tracks the energy fluctuations in the child’s play as an indicator of the child’s subjective feelings of safety. In this manner, the child controls the gradual imaginal exposure to abuse-related material.

It is our experience that children engaged in Developmental Transformations will symbolize the abuse story when they feel safe with the specific therapist as a non-abusive and reliable adult. Nontraumatic and low- arousal themes are developed until the child can tolerate prolonged imaginal exposure to traumatic material. Through repeated imaginal exposure, traumatic representations are gradually desensitized over time.

Touch is not discouraged when initiated by the child in the play space. However, the therapist does not introduce touch directed toward the child’s
body during the course of play. In contrast, the therapist’s body is available to the child for contact comfort and in the service of role-play. In effect, the therapist using developmental transformations submits the use of his or her body in the service of telling the child’s story and does not guide the child through (therapist-controlled) predetermined exercises or therapeutic techniques. For sexually abused children with poor body boundaries who use aggression instrumentally with others, the therapist models ways in which the child’s aggressive impulses can be represented in the play space and not acted out in reality, therefore creating negative consequences in interpersonal relationships.

It is our feeling that this unique organization of the power differential proposed in the theory and practice of Developmental Transformations between the child and the non-abusive adult helps the child regain a sense of empowerment. This process provides the child with an experience of adult attention and intimacy that can be differentiated from memories of sexual victimization by the perpetrator. Playful and positively toned emotional experiences with the therapist characterized by pleasure, safety, and control can be internalized in contrast to the experiences of terror, shame, loss of control, and betrayal associated with the memory of the perpetrator.

The specific goals of using Developmental Transformations with sexually victimized children are: (1) to encourage the reembodiment of the child; (2) to reduce the utilization of arousal and dissociation as coping strategies; (3) to access traumatic material for imaginal exposure and integration; and (4) to modify distorted shame-based cognitive representations of self and other. Over time, the internalization of positive interactions with the playful therapist can ameliorate the painful effects of internalized shame.

Course of Treatment

After completing the interviews, medical examinations, and forensic evaluations, Jamaar refused to speak further about his uncle or his biological parents. He did not recant his story. However, now, when his family was mentioned, Jamaar clenched his fists and became silent. He was aware that the authorities did not believe his story. He asked the therapist, “Why didn’t they do anything to him?” Jamaar could remember what happened, he told us in his own words that his uncle “put his dick in my butt”; however, Jamaar now refused to speak about his sexual abuse.

The fact was, Jamaar was still living next door to his biological parents and his uncle, nothing happened to the abusive adults, and Jamaar felt he was the one who was blamed for the sexual abuse. The therapist said to Jamaar, “I can imagine you still don’t feel safe.” Jamaar quietly replied, “You can’t do anything.” Indeed, Jamaar was correct. After repeated attempts to intervene with prosecutors and child protective caseworkers, it was clear that the authorities were not swayed to change the location of Jamaar’s foster placement.

In his mind, Jamaar interpreted the sexual abuse, repeated evaluations, and foster placement as his fault. What the perpetrator had warned would happen to Jamaar if he told anyone, did come to pass. Jamaar was the one who got in trouble; he had to move out of his apartment and did not get to see his parents. Jamaar felt the shame of telling his story to so many “white” strangers and became highly suspicious of authorities. He did not experience the protective interventions as they were intended, instead feeling exiled and alone. As a result of the poor response to his disclosure, Jamaar began trying to suppress the memory of what happened.

Now, when asked how he was doing, he said, “Fine.” However, his arousal symptoms and dissociative coping increased. He got into more trouble at school. His foster mother complained, “I have to tell him over and over what I want him to do, he never listens.” His teachers described him as “spacey, hostile, and distracted.”

Assessment Phase

Jamaar was assessed to be physically expressive and predominantly non-verbal. The therapist offered Jamaar a range of expressive art materials. He obsessively drew pictures of large, muscle-bound male figures dressed in wide shoulder pads like football players. These figures held various automatic weapons and explosive devices in their gloved hands. They were a combination of football players, video game characters, World Wrestling Federation wrestlers, rappers, and Special Forces soldiers. He did not draw anything else and lost interest in drawing altogether after two assessment sessions.

The therapist rehearsed Jamaar in having a puppet tell him he was safe in his room at night. Jamaar liked the puppet and took it home, keeping it until completing therapy two years later.

During the third session, Jamaar walked over to the playroom and asked if he could play instead of drawing pictures. The playroom was empty except for a few pillows in the corner (by design). He asked the therapist, “Where are the toys?” The therapist told him, “I am the toy.” Jamaar smiled and began an imaginary basketball game with the therapist.

Jamaar spent his first Developmental Transformations session making imaginary basketball shots. His body was fully involved in this activity and, at the end, both he and the therapist were sweating. The therapist was never allowed to score a point. The therapist imagined making the point, throwing up his arms in triumph and saying, “Yes!” Jamaar took the imaginary ball and said, “No, you missed it.” Jamaar was never blocked either, making every point, no matter how unlikely the shot. Jamaar made the rules. The
therapist decided to follow cues to his imaginative world for as long as Jamaar wanted to repeat running to the backboard and making slam-dunks.

During the basketball play, the therapist commented aloud to Jamaar that these rules were “Jamaar’s rules for trust.” After so many adults had betrayed and abused him, or failed him, it would be a while before Jamaar would trust anyone. At the end of this session, the therapist offered Jamaar an imaginative “key” to open the “magic box.” Only Jamaar and the therapist could open this particular box, using special sounds and movements. Jamaar and the therapist named everything they had created together during the session and put it in the imaginary box. This dramatic ritual, demonstrated in an embodied way, separated reality from fantasy, the imaginative world from the real world. The “box” became a framing ritual for the therapy. Jamaar and the therapist co-created the magic box at the beginning and end of every session.

During the next few sessions, Jamaar bumped or hit the therapist “accidentally.” He wanted to punch, jump on, and push the therapist for real. Jamaar had poor body boundaries. He had to be taught how to use the conditions of the playspace, how to use his imagination. It was easy to see why he was in so much trouble on the playground and in school. The therapist explained to Jamaar that he couldn’t really hit the therapist and demonstrated how to represent his aggressive impulses in the playspace. The therapist explained to Jamaar that acting on his anger for real at home and school gets him in trouble. The therapist told Jamaar, “Here you can pretend and you won’t get into trouble.” Jamaar listened intently and accepted this convention for the play. Jamaar agreed with the therapist that he didn’t want to get into trouble, but he didn’t know what to do with the rage inside.

Offering this imaginative convention for play was an important hook for Jamaar to engage with the therapist. Jamaar was filled with rage for obvious reasons, and needed concrete (close to the body) dramatic structures to contain and express his intense feelings in a safe way. He enjoyed learning and practicing how to hit, shoot, machine-gun, and blow up the therapist with hand grenades. The more imaginative he was, the more fun he had. The therapist got up off the floor each time, dusted off, and asked Jamaar, “What else can you do to kill me?”

During the next few months, Jamaar imported characters from external sources such as TV, video games, and movies. He was unable to elaborate his imagination to any significant degree. He did not create characters, but used only ready-made characters and settings. The therapist became aware that, as a result of neglect, Jamaar had not been engaged interpersonally in imaginative play during the course of his early development. The therapist imagined that Jamaar was probably socialized (babysat) by the TV and the

Game Boy. Robots, MTV video characters, and high levels of aggression characterized his inner world.

Initially, Jamaar would only identify with the omnipotent, all-powerful aggressor in his play. The therapist was always cast to play the weak, denigrated, ashamed, and powerless characters. By Jamaar’s design, the therapist could be shot or blown up repeatedly. In contrast, Jamaar could not be wounded in any way. During this phase of treatment, Jamaar would not allow the therapist to transform the scene or offer any deviation in the themes. Jamaar’s style of play was controlling and rigid, with no reciprocity. The intense sounds of rage—the yelling and growling—that he made were sometimes heard outside the playroom.

Jamaar imported into the playspace whole movie scenes from Jackie Chan action movies. He played scenes from “Chucky” (Child’s Play) and Friday the 13th movies. Jamaar used imaginary knives to stab the therapist. During one session, Jamaar chopped up the therapist and ate him piece by piece. For a series of intense sessions, Jamaar played “the general” from The Planet of the Apes (2001). He played this role with uncanny physical skill, imitating the movements and vocal grunts of this character with great effectiveness. He jumped, rolled, and strutted around the playroom. The therapist was always cast as the weak human, locked in a prison cell, totally dependent on the ape keepers for food and shelter.

The therapist was aware that Jamaar was teaching him how it felt to be out of control, afraid, abused, humiliated, and bored, feelings that he probably had felt frequently before his placement in foster care. Jamaar was teaching the therapist what it felt like to be in the body of the victim by enacting the aggressor role exclusively. During one session, the therapist (from inside his prison cell) commented, “Jamaar, I bet you felt out of control most of your life.” Jamaar said nothing, but the energy in his play increased.

The therapist submitted fully to the parts he was cast to play and continued to comment to Jamaar how it felt to be weak, afraid, and alone. In the beginning of this phase of treatment, Jamaar did not want to hear it. He enjoyed “taking away” the therapist’s voice. With a magic wave of his hand, he would mute the therapist, and the scenes would continue in silence.

During one session, Jamaar pummeled the therapist in the boxing ring round after round. Jamaar won the world heavyweight title each time. It was not fun to play with Jamaar. The therapist commented from inside the boxing ring, “Now I understand why you don’t have any friends. If you play this way with them all the time, always telling them what to do and never letting them win, they won’t want to play with you anymore.”

After about six months, Jamaar turned the characters of Chucky, Jason, the general, and the boxer into “made-up monsters.” Jamaar still wrote the script and took the role of aggressor, but now he allowed the therapist to
join him as a “helper” in killing the monsters. Jamaar began to allow the therapist to have some power in the session. The plots became more elaborate and imaginative. The therapist was the one to get wounded, and captured by the monsters, for Jamaar to rescue him. However, Jamaar never got wounded himself. During this time, Jamaar demonstrated more caring behaviors toward the therapist, going into the cave of the monster to rescue him, then bringing him food and attending to his wounds. A symbolic language was fully established in the play space. The therapist had the feeling that Jamaar knew he was communicating his thoughts and feelings in this symbolic way. His gaze was direct and intimate. This was a change that both the therapist and Jamaar noticed, as the felt intimacy between them had deepened.

Eventually, Jamaar let the therapist play the monster, as well. Jamaar was given “a freeze gun” to immobilize the monster when he wanted (and before he became hyper-aroused and disembodied). The theme of the monster now appeared to be both frightening and exciting for Jamaar. He was given “safe places” in the playroom, like “the cave” and “the castle,” and he could fly away using his “dragon/eagle wings.” During one session, Jamaar turned into a falcon, flying high above the ground. He became other animals such as tigers and snakes. Based on the reports of his foster mother and his teachers, Jamaar was more confident and relaxed outside the playroom. He had stopped fighting at school.

Jamaar “captured” the therapist and put him in a cave, a pit, and the closet. His energy was very high during this kind of play. The therapist was aware that Jamaar was slowly approaching his sexual abuse experiences from a symbolic distance. The therapist was also aware that Jamaar would still only identify with the powerful characters. Jamaar did not allow himself to identify with the vulnerable, small, hurt, or weak aspects of self. He kept his wounds at an emotional distance while he attended to the imaginary wounds of the therapist. The therapist was aware that Jamaar was teaching him what it meant to be wounded.

The therapist provided Shirley several sessions of psycho-education regarding sexually abused children. She helped identify possible triggers in Jamaar’s environment. The biggest problem was that Jamaar was seeing his uncle most mornings when he went to school. In the evenings, his biological parents sometimes sat on the stoop of their apartment and stared at Jamaar and Shirley when she brought him home. Jamaar would then urinate in his bed that night, for which he felt very ashamed.

Shirley did everything she could to reduce the contact with the perpetrators. She enrolled Jamaar in a new school with a smaller classroom. Jamaar made a few friends at his new school and went to camp that summer, where he did not identify himself as “a problem.” Shirley filled out the papers for a subsidized mortgage so that she could afford to move. Jamaar stopped urinating in his bed so often, which made Shirley very happy. She learned to help him put the bed sheets in the washing machine and dryer without yelling, and then remind Jamaar that he was safe in her house. She started to attach emotionally to him. Jamaar did better and Shirley did better; this was good for both of them.

After about nine months of treatment, Jamaar began to develop more trust in Shirley and the therapist. The new caregivers in Jamaar’s life attempted to differentiate their behavior from that of his biological parents, his uncle, and the authorities who did not respond to his disclosure. They tried to make their behavior toward him as consistent, supportive, and firm as they could. They directly communicated their high expectations for his behavior. Eventually, “Chucky” stopped coming into Jamaar’s nightmares and he slept through the night in his own bed. The incidents of enuresis continued with less frequency.

Jamaar introduced into the play space an elaborate game he had made up. In this game, the therapist was made to stand up facing the wall with his back to Jamaar, close his eyes, walk back slowly, keep his eyes closed, and try to tap Jamaar. If Jamaar got by the therapist to the wall, he got a point. If the therapist tapped Jamaar before he reached the wall, he got the point. Needless to say, it was nearly impossible to tap Jamaar. He would crawl, make leaps, sneak, dive, and simply run by the therapist in order to touch the wall and yell, “Yes!” He then humiliated the therapist by calling him “slow and stupid.”

The game required actual physical skill. It was fun to play for both Jamaar and the therapist. The therapist introduced the role of a “TV announcer,” and played both the denigrated competitor and the announcer who cut to commercials for Reebok. Jamaar liked these dramatic structures. He participated in the “after-the-game interviews” for the studio and TV audience.

Both the therapist and Jamaar played the studio audience, wildly cheering for Jamaar when he made a point. During some games, Jamaar played for his favorite causes, for “world hunger” or for “justice” for African-Americans. During one session, the therapist noticed that Jamaar had focused his attention on the white skin of the therapist. The game was then played between the “whites versus the blacks,” then the tall versus the short, the fat versus the skinny, boys versus girls, teachers versus students, victims versus perpetrators.

Both the therapist and Jamaar became good at playing the game, which required some very particular skills. For instance, you had to be very silent or still when trying to get past the player with eyes closed (who could only
listen for sounds). Conversely, you had to listen very intently for any minimal sound when trying to tap your opponent. The therapist became aware that JAMAAR was teaching him what it was like to try to avoid his uncle's sexual perpetration at night. Playing the game allowed the therapist to imagine what it may have been like for JAMAAR to wait, to listen for his uncle at night, to be silent and lie still, to pretend to be asleep.

During one session, JAMAAR turned off the lights and the game was played in the dark. JAMAAR did not want to be seen. The therapist gave him an "invisible button" that he could press whenever he wanted. The lights were turned back on. When JAMAAR pressed the button, the therapist acted as if he could not see JAMAAR. JAMAAR loved the invisible button. He used it often.

One session, during the game, the therapist said, "I bet it would have been great to be invisible when your uncle came for you at night." He nodded and played on. The therapist then said, "I bet peeing in the bed was a good idea to keep your uncle away, too." JAMAAR stopped and looked at the therapist intently. "Yes," he said. The therapist took up the imaginary microphone and announced, "Boys and girls, JAMAAR is here to play the game on behalf of all of those children whose uncles put their 'dicks in their butts'; he is your champion." These were the exact words that JAMAAR had used in his verbal disclosure to forensic evaluators during the initial assessment. The therapist then enrolled as his uncle trying to "zap" JAMAAR. The energy in this series of sessions was very high. When JAMAAR scored a point against his uncle, the crowd went wild with cheers. JAMAAR put his arms up in the air whenever he would score a point against his uncle. JAMAAR would then relish his wins and put down his uncle (therapist) in front of the studio and TV audience. The game went on like this for a few months. During one "postgame interview," the announcer asked JAMAAR: "The boys and girls in the audience want to know how you deal with your sexual abuse?" JAMAAR said, "You tell your foster mother and your therapist; you do good in school; don't fight; you just keep going."

"The boys and the girls" became regular characters in this repeating dramatic plot. JAMAAR gave them a "press conference" at the end of the session, giving advice on all kinds of subjects, like how to do better in school. He explained to the "kids" what to do if someone tried to have sex with them. JAMAAR told them that what his uncle did to him was wrong, and the sexual abuse was not his own fault. He told the kids that there were some good things about his uncle, that he missed his parents, and that he could not understand why the police "didn't do anything."

Soon, Shirley expressed her desire to adopt JAMAAR. However, JAMAAR became anxious when the topic of adoption was brought up. He did not want to discuss the possible adoption and he did not want to return home to his biological parents. He pushed aside the subject when Shirley or the therapist mentioned the topic.

During one session, JAMAAR stopped playing the game. In a spacy or dreamy way, he stared at a black scuff mark on the wall of the playroom. There was a long pause. The therapist said, "You know what is behind that door, don't you?" JAMAAR answered, "Yes, that is where they live." The therapist asked JAMAAR what he wanted to do. "I want to kill them," he said. The therapist said, "No, you are not ready to face your uncle and your parents." JAMAAR looked overwhelmed (aroused), his fists clenched. He was shaking with rage and was not in the playroom.

The therapist held up an imaginary key to the "other house" and said, "I will hold the key until you are ready to face them." JAMAAR began to laugh and said, "I am ready," lunging for the key. The therapist moved out of the way and kept the key out of JAMAAR's reach. They played in this way for one session. JAMAAR enjoyed this game of "keep away." By the end of the session, he was back in the playroom.

During the next session, the therapist warned him that if he opened the door, he might feel sad and cry. JAMAAR said, "I don't care," doubling his efforts to get the key. The therapist finally agreed to help him open the door. Together, they opened the door with pretend difficulty. Once it was opened, a huge wind came and sucked the therapist through the door. JAMAAR grabbed him and held on. JAMAAR pulled hard to keep the therapist from being taken into "the house." Back and forth, both JAMAAR and the therapist fought to get free of the pull. Then, after an "explosion," his uncle, mother, and father came out of their house and attacked JAMAAR and the therapist.

The therapist and JAMAAR fought the perpetrators bravely. This time, JAMAAR got wounded. An arrow pierced him in the chest, "in my heart." JAMAAR allowed the therapist as "the wizard" to administrate to his wounds for the first time. The wizard lived in a "safe cave" and was powerful with magic. As the wizard, the therapist dressed JAMAAR's wounds and gave him nourishment to build his strength.

During one of the "battle sessions," JAMAAR was wounded and crawled into the wizard's lap. The wizard attended to his wounds and sang the "warrior song." JAMAAR began to cry softly. The wizard changed the song to the "song of JAMAAR," using the real circumstances from his life in the lyrics of the song. JAMAAR let himself cry with full sobs—tears for his lost childhood. While he cried, he listened as the therapist sang the story of his life. Slowly, his sobs became quieter and his breathing calmer and more regular.

JAMAAR received some "gifts" from the wizard. The wizard gave JAMAAR the potion for healing sexual abuse, the book of his life so far, and a sword to protect him in the future. JAMAAR seemed pleased with these gifts.
During the next few months, Jamaar played these battle scenes repeatedly until he felt he had overcome the "monsters." He accepted his wounds and the attention of the caring therapist. Shirley was approved to adopt Jamaar, and he became comfortable with the idea of having her as his new mother. Shirley decided to move after the adoption was made final. Jamaar and the therapist prepared to say goodbye.

**Closure**

Jamaar had come a long way. He did not fight at school anymore, he had stopped urinating in his bed at night, and he was no longer afraid of his monsters. He now had a life story with a hard beginning, a dark period in the middle, but an open future. The adoption was finalized. Jamaar had a new last name that he chose to use.

As part of the closure process in therapy, the therapist conducted an adoption ceremony for Jamaar and his new mother, Jamaar, his mother, and a few invited guests listened as the therapist read "the story of Jamaar" to the group. During the ceremony, his foster mother stood up in front of everyone and said, "I take you as my son." Jamaar answered, "I take you as my mother." The "witnesses" at the ceremony said in unison, "We hear your story, you have done well, we witness this new family." There were tears shed and some cake was served.

Two months after the adoption ceremony, Jamaar and the therapist opened the magic box for their last session. Together, they imagined what they might be like in 20 years. They imagined the therapist walking with a cane and Jamaar visiting with his own children. He and the therapist reviewed all of the characters, games, and battles they had created over the 2-year process. They played "the game" one final time and gave each other imaginary gifts. Swords, trophies, medals, and storybooks were exchanged. Jamaar was given the real puppet to keep. At the end of the session, they gave each other a hug and said goodbye.

The therapist knew that Jamaar was inside of him forever and hoped it was the same for Jamaar. The therapist hoped that Jamaar would take the playspace inside of him, to contain his helpers and his monsters as he grows up. The therapist hoped they had had enough time in the therapy process to allow Jamaar to identify with his wounded self, not just the perpetrator.

**Conclusion**

Jamaar, at 8 years old, had the courage to tell his story. Because of the initially poor responses by protective adults, Jamaar began to suppress his story and try to forget what happened. This defensive process had the effect of increasing his arousal and aggression at school and at home.

Jamaar told us in words that he was "fine." However, his behavior (his body) told us a different story. He was fighting every week in school, urinating in his bed most nights, having nightmares, dissociating, and acting out sexually with other children. Hyper vigilant and mistrustful of adults, he believed that the sexual abuse perpetrated by a boy eight years older and stronger than him was somehow his fault. His aggressive behaviors were understandable and adaptive in the home of his biological parents. There, his behaviors of vigilance and mistrust made sense. Jamaar developed these behaviors in an environment where he needed to survive. In treatment, Jamaar needed to learn interpersonal coping skills appropriate for the new protective environments of school, the foster home, and therapy.

When Jamaar began treatment, he was sometimes not in his body or, at other times, too much in his body. His body had been the target of sexual attention from his uncle, the locus of painful physical intrusion and shame. For Jamaar, being in his body was not experienced as safe or pleasurable. Disturbing visual images and a felt sense of painful arousal came without his control. Engaged in Developmental Transformations, Jamaar slowly reinhabited his body and regained a felt sense of safety and control. This embodied method of drama therapy provided Jamaar with a cognitive developmental middle path between suppressing the story (avoiding, numbing) and being continually aroused by traumatic memory (re-experiencing, hyperarousal).

The trauma story, encoded in implicit memory systems needs to be translated into explicit, representational form (including words) for desensitization to occur. Affective dysregulation in sexually abused children is the failure to develop forms for feeling. The method of Developmental Transformations allows the traumatic sense memory to be accessed, contained, represented, and placed in the child's narrative past. The therapist using this method can provide the sexually abused and neglected child an emotional prosthesis for further cognitive affective development within a safe interpersonal environment.

Finally, for trauma therapy to have an impact beyond symptom relief, the distorted cognitive affective representations of the self and others must be accessed and modified within a novel and non-abusive interpersonal encounter for internalization. Ultimately, we do not want sexually abused boys and girls to develop into adults who are symptom-free yet identified with an aggressor; thus, replaying the trauma story in another generation of children. The deep and often distorted cognitive structures of the victimized vulnerable self and perpetrating other have to be accessed and modified in order for the child to develop internal representations of a loveable self and safe others. This is not a short-term process. To be successful, this
process requires a warm, courageous, and consistent therapist, safety, symptom relief, relational work, and enough time.

References


CHAPTER 5
Creative Co-Constructions
A Psychoanalytic Approach to Spontaneity and Improvisation in the Therapy of a Twice Forsaken Child*

ROSALIND CHAPLIN KINDLER

Introduction
It is 1985, and I am standing in a playroom facing the door to the waiting room. I am nervous. On the other side of the door there is silence. A 6-year-old boy waits there with his mother. They’ve come for his first therapy session. For me, this is the first session of my very first case in the process of training to become a psychoanalytic child therapist—new territory. Until now, I have been a drama teacher. I know that the only thing I can be sure of right now is that I don’t know what’s going to happen for the next hour. Then, I remember a time not so long ago when, as an actor, I was about to do an improvisational exercise with another actor. I remember feeling held by the certain knowledge that, whatever happened between us in the improvisation, we would be guided by the authenticity of simply being and staying in the moment. This memory calms me. I feel much better. This is familiar ground, after all. “Just think of this as another improvisation,” I tell myself, as I open the door.

Psychoanalysis and Drama Therapy
I am among the fortunate who have been able to count Dr. Eleanor Irwin as mentor, supervisor, friend, and esteemed colleague. My introduction to Ellie

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