

INSTITUTE FOR CLINICAL SOCIAL WORK

THE PROBLEM WITH PLEASURE

A Dissertation Submitted to the Faculty of the  
Institute for Clinical Social Work in Partial  
Fulfillment for the Degree of Doctor of Philosophy

By

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Chicago, Illinois  
March, 2010

## ABSTRACT

This study explores how adult survivors of chronic abuse and neglect define pleasure, the disruption of pleasure, and the repair of the capacity for pleasure in the context of the therapeutic relationship. Using narrative methodology, 15 clinical pairs of patients and their therapists were each interviewed separately. Thematic analysis revealed eight findings. All patients reported the capacity to experience pleasure throughout life prior to therapy. Subjects defined pleasure as a variety of positive affects, which fell into two categories: pleasure in activities and interests and pleasure in relationships. All patient-subjects reported a history of traumatic disruption of pleasure in childhood. Some patient-subjects reported a history of internalizing and reenacting their own disruption of pleasure. Narratives of the patient-subjects were consistent with the narratives told by their therapists. In many clinical pairs, both parties spoke positively of an important therapeutic event when the therapist stepped out of his or her usual treatment frame. Safety, consistency, reliability, predictability, and compassionate caring were spoken of throughout the sample as elements that created a pleasurable and therapeutically reparative relationship. Patient-subjects spoke repeatedly of the importance of “finding a self” to the experience of pleasure. Pleasure enhanced the ability to find a self and “finding a self” enhanced their capacity for pleasure. This study invites further research to investigate the function of pleasure in the process of therapeutic repair for the chronically traumatized population.

For my subjects, whose courage and generosity made this possible.

## ACKNOWLEDGEMENTS

It takes a committee to produce a dissertation. I am grateful to Dennis Shelby, Ph.D., who understood what I was talking about all along and provided numerous detailed maps to guide me on my journey, while providing refreshments along the way. I want to thank Joe Palombo, MA, my theoretical mentor, who insisted that I live up to my potential and invaluable helped me clarify my thoughts and those of other theoreticians throughout our work together. I thank Joan DiLeonardi, Ph.D., who taught me to be a researcher, nurtured my interests, and unflaggingly expressed her belief in me.

It takes two readers to make sure you get there. This work could not have been done without the generous mentoring of Constance Goldberg, MS, whose clear editorial eye and swift hand have made me look better than I am, time and again. Freddi Friedman, Ph.D., bravely stepped in to help in difficult circumstances and lent her skilled reading and warm support to this endeavor.

This manuscript is dedicated to the memory of Marcia Adler, MA, who we all loved and who we all miss. She started this work with me and my only regret is that she is not here now to see its fruition. We would have had a good time.

And I thank Dave Corzine, MSW, my first reader, best critic, and ever-patient life partner and husband, with more gratitude than I can possibly express.

J. M.

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## CHAPTER I

### INTRODUCTION

#### Significance of the Study for Clinical Social Work

Many people presenting for therapy, even without a known or reported history of traumatic abuse, report difficulties in experiencing pleasure. Clinical attention to the problem of pleasure may significantly leverage therapy by engendering substantial gains in resiliency. Individuals bring to clinical treatment both self-capacities and deficits, which affect the experience of pleasure. Perhaps by understanding more fully the interface between problems with pleasure and our therapeutic interventions, we can enhance our therapeutic work to more fully engage resiliency in hastening patient recovery through the restoration of their capacities for pleasure.

#### Formulation of the Problem

This study follows on previous work by the author (Migdow, 2003), exploring problems with pleasure in adult survivors of chronic childhood abuse and neglect:

Survivors of severe, chronic childhood trauma, including those with dissociative disorders present for therapy with a wide range of symptomatology that interferes with daily functioning. Fragmentation and PTSD disrupt the capacity for integrated and satisfying relationship development, which affects the social, professional, and intimate lives of survivors. The literature on resiliency indicates that certain protective factors, including individual capacities, may allow some survivors to more easily overcome circumstances of extreme neglect and abuse. Restoration of equilibrium, the capacity for a unified self, and reconnection with

community are normative treatment goals. The problems with pleasure are generally not addressed in the literature.

Understanding the underpinnings of pleasure in the human psyche, the importance of pleasure as an organizing principle in psyche life, and the sources of disruption to pleasure-seeking behavior—particularly in survivors of severe childhood trauma—are all topics of interest.

### *The Population*

The problem of pleasure may be central to the life dilemmas of children and adults who have survived child abuse and neglect. This population is enormous. The U.S. Department of Health and Human Services and National Center on Child Abuse and Neglect investigated allegations of an estimated 3,598,000 reports of six million maltreated children in 2005 (U.S. Department of Health and Human Services, 2005). In 2005, 1,490 children died, while an estimated 899,000 children were found to be victims of abuse or neglect; 80% of these children were injured by their own parents (U.S. Department of Health and Human Services, 2005).

Children and adult survivors present a variety of symptomatology, which includes depression (Browne & Finkelhor, 1986; Polusny & Follette, 1995), anxiety disorders (Mancini, et al., 1995), self-mutilation and suicidal behavior (Green, 1978; Van der Kolk, Perry, & Herman, 1991), sexualized behavior in children (Cosentino, et al., 1995), sexual dysfunction in adults (Russell, 1986), substance abuse (Dembo, et al., 1987, 1990), complex post-traumatic stress disorder (PTSD) (Herman, 1992), and dissociative disorders (Saxe, et al., 1993; Putnam, 1997). Putnam states, “most studies find that the

majority of traumatized children manifest one or more symptoms that fall within the core PTSD symptom set” (1997, p. 32).

Additionally, the DSM-IV-TR (2000) contains a long list of features commonly associated with PTSD, including phobic avoidance, impaired affect modulation, somatic complaints, impaired relationship functioning, shame, despair, and hopelessness. All the aforementioned clinical problems may have, at their core, a loss of equilibrium, which induces the avoidance of, disruption of, or inability to experience pleasure. Loss of equilibrium may be seen as having both psychological and physiological origins and manifestations.

### *The Nature of Trauma*

Both Freud (1953/1896) and Janet (1907/1889) originally located the origin of hysteria in the dissociation of childhood sexual abuse and trauma. Despite their original concurrence, Freud’s abandonment of the seduction hypothesis in 1897 (1897/1953) began a conflict in the literature about the nature of trauma, its origins, resulting symptomatology, and psychodynamic mechanism. Pavlov’s (1927) original conditioning experiments, followed by Watson and Raynor’s (1920) research into the formation of phobias, added a behavioral perspective.

This perspective, which was later expanded upon and clarified by Seligman (1971), allowed us to begin to perceive trauma not only as a psycho-physiological event, but also as an event that had both long-term psychological and physiological sequelae.

As modern psychological research progressed and brain imaging became possible, neuropsychology opened yet another avenue for exploring the physiological substrates of

trauma (De Kloet, Oitzl, & Vermetten, 2008). This work, along with ethological data (Morris, 1967) and its applications to human conditions, lends invaluable information about the psycho-physiological states known as PTSD.

All mammals, including human beings, move through a series of predictable responses when confronted with danger (Morris, 1967; Levine, 1997; LeDoux, 1996). The initial freeze response helps protect animals from detection and allows them to take time to orient themselves to where the danger is coming from and in what form.

Simultaneously, the limbic system processes the stimuli and loads the body with catecholamines. In bypassing the cortex to send an emergency message to the amygdala, the animal is best prepped to physiologically (if detected by a predator) flee if possible, fight if it must and can, or freeze when no other viable options remain. LeDoux hypothesizes that this process not only creates implicit memories that are unavailable directly to consciousness, but also accounts for traumatic memories being held more vividly (LeDoux, 1996). This is seen as the brain's way of quickly and deeply learning what is critical to the animal's survival.

Part of this learning seems related to an additional chemical cascade, which stems from the opiate system (Goleman, 1995). Endogenous opiates, such as endorphin, inhibit pain, helping the body to endure and cope in emergencies. Van der Kolk stated that, "Two decades after the original trauma people with PTSD developed opioid-mediated analgesia in response to a stimuli resembling the traumatic stressor" (1996, p. 226–227).

Clinically, these long-lasting physiological effects of hyperarousal, intrusive re-experiencing, and avoidance/numbing are typically seen in those diagnosed with PTSD and dissociative disorders. Each of these symptom sets may interfere with the experience

of pleasure in unique ways. Additionally, the overall disruption of equilibrium prevents many trauma survivors from experiencing any consistent sense of well-being (Briere, 1996; Chu, 1998; Herman, 1992; Putnam, 1997).

### *Statement of the Problem Studied and Specific Objectives*

Survivors of chronic childhood abuse, including those who present with dissociative disorders, exhibit a wide range of symptoms that interfere with their ability to live productive and fulfilling lives. Therapy is often lengthy and arduous. Restoration of equilibrium, the capacity for a unified self, and reconnection with community are normative treatment goals (Herman, 1992; Davies & Frawley, 1991, 1994; McCann & Pearlman, 1990; Putnam, 1989). The problems with pleasure are not often discussed.

Survivors may lack not only basic self-knowledge about their internal states, but also any awareness about how to empathically regulate these states. They may experience chronic depression and/or anxiety disorders with subsequent feelings of helplessness, hopelessness, and despair (Briere, 1996; Chu, 1998; Mancini, Amerigen, & MacMilan, 1995). Numbing blocks the experience of sensation and emotion, excluding the possibilities of pleasure, enjoyment, and joy. Hypervigilance in defending against assault precludes spontaneity, creativity, and the positive self-absorption in task, which are critical to “flow” (Csikszentmihalyi, 1990, p. 4). Flow is that experience in which “concentration is so intense that there is no attention left over to think about anything irrelevant, or to worry about problems” (1990, p. 71). It includes joy, creativity, and the process of total involvement with life, which Csikszentmihalyi defines as “optimal experience” (1990, p. 3).

Often in situations of sexual violence, survivors have been led to believe they were willing participants in their abuse, though not consenting; they believe they are at fault, because their bodies were manipulated to respond with pleasure (Courtois, 1988; Justice & Justice, 1979; Russell, 1984). Their sexual addictions can become a form of self-punishment, while sexually avoidant behavior becomes a means to fend off the feeling of having colluded with the very people who injured them (Chu, 1998; Putnam, 1997).

In the worst-case scenarios, survivors become predators who obsessively seek heightened stimulation through control that never fills the void inside of them. Instead, they deepen their indifference to the pain created in those they exploit for the sake of their own arousal (Gilligan, 1997; Meloy, 1992; Salter, 2003).

Additionally, excitation, which is critical not only to sexual arousal, but to all risk-taking and exploratory behavior, is often physiologically and psychologically paired with negative affects or sensations related to the trauma. While survivors of childhood abuse often lead depleted lives, trauma-based therapies generally make little mention of addressing the issue of pleasure directly, implying that this capacity will naturally reassert itself with proper treatment (Briere, 1992, 1996; Courtois, 1988; Chu, 1998; Dalenberg, 2000; Gil, 1988; Herman, 1992; Levine, 1997; McCann & Pearlman, 1990; Putnam, 1989, 1997; Ross, 1989; Salter, 1995; Shapiro, 1995; van der Kolk, McFarlane, & Weisabeth, eds., 1996).

This belief deserves examination. Bessel van der Kolk (1999), in remarks made at an International Society for Traumatic Stress Studies (ISTSS) symposium in November of 1999, asked the question, “Can a focus on mastery and pleasure help people

distinguish between trauma-based arousal and other modes?" This question and relevant answers may critically inform our therapeutic process.

This exploratory study poses that addressing the problem with pleasure may be core to the treatment of traumatic disorders. Can the capacity for pleasure be retrieved by addressing these issues in both the process and content of the therapeutic relationship?

## CHAPTER II

### LITERATURE REVIEW

The first question is one of definition: How do we define pleasure? How authors in the literature define pleasure may well vary from author to author. These conceptual explorations of pleasure set the boundaries of the literature to date and inform thinking about human regulation and dysregulation, comfort and discomfort, pain and pleasure. For purposes of this study, pleasure will be defined by the subjects. Exploration of the literature will inform understandings of this data.

#### Early Psychodynamic Theory

Freud was certainly one of the earliest commentators on the significance of pleasure in our lives. Freud (1905) saw libidinal energy as part of one of the primary drives organizing human existence. Freud defined libido as the mental energy connected to the sexual drive or instinct. In Freud's (1915) view, drives are innate; they are species-specific, hereditary instincts sourced in the body, which organize human behavior towards the relief of tension. In this mechanistic, hydraulic model, the body is seen as accumulating tension that seeks relief.

“Tension buildup” becomes Freud's initial definition of unpleasure or anxiety and “tension relief” defines pleasure. Constancy is the aim. In this model, our unconscious

wishes and desires are organized primarily around the avoidance of unpleasure, rather than the seeking of pleasure.

In *Beyond the Pleasure Principle* (1920), Freud expands this initial discussion along several lines. First, he refines his concept of pleasure not as a simple reduction of tension, but as “the amount of increase or diminution in the quantity of excitation in a given period of time” (1920, p. 8). He goes on to discuss individual differences in regulatory capacity so that the experience of pleasure or unpleasure begins to be seated within excitation over time, endowment, and prior life experience. Unpleasure is not just tension buildup. Freud (1920, p.10) acknowledges that “the replacement of the pleasure principle with the reality principle can only be made responsible for a small number, and by no means the most intense, of unpleasurable experiences.” Danger is a predominant factor.

Freud now defines anxiety not by tension buildup, but as a response to danger—a warning, a signal. In this schema, individual differences exist in both how much stimuli overwhelms the individual and the effectiveness of the signal anxiety in warning of danger. Trauma results when these capacities to protect are overwhelmed.

“Traumatic neurosis is a consequence of an extensive breach being made of the protective shield against stimuli” (Freud, 1920, p. 31). Tension buildup, overwhelming experience, and the individual differences in the desirability of different levels of excitation over time all affect the experience of or lack of pleasure.

Freud goes on to further modify his views by contrasting the life instincts as opposed to the death instincts. The life instincts now include both the sexual instincts propelled by libidinal drive and the instinct for self-preservation, previously referred to as

the ego instincts (1910). The life instincts can be in conflict with each other, as well as being in conflict with the death instincts. The ego instinct is seen as coming under the sway of the reality principle, while the sexual instinct continues to be driven by the pleasure principle. Can we relieve the tension of sexual desire or must we repress the desire itself? Can we adapt by sublimating those desires into creative expression, and thus relieve the tension in a socially acceptable and even productive manner?

Primarily, the reality principle mandates that the child not only redirect through repression his incestuous desires, but also redirect his narcissism towards an external object that is no longer his parent. Primary narcissism, the inborn directing of libidinal energy towards the self, is seen as proceeding and, therefore, absent of object relating. Secondary narcissism is seen as a withdrawal of libidinal energy from the object, which is then turned back upon itself (Freud, 1914, 1917).

In this view, the libidinal drive can be at odds with the needs of both self-preservation and species preservation. Civilization mandates socialization of humanity. The child must give up the tension relief found in his mother's body by repressing the incestuous libidinal urge to bed or own the body and being of his parent. In doing so, he resolves the oedipal complex, represses the wishes and desires associated with an id organized around pleasure seeking, and incorporates a superego with all the attendant prohibitions necessary to keep his anti-social pleasure-seeking behavior in check. In the best of resolutions, the libidinal drive is sublimated into artistic expression and otherwise redirected at the proper developmental age towards an appropriate object.

Healthy development within this model posits that there is a conflict between the pleasure principle and reality principle (Freud, 1911). The reality principle mandates

complete adaptation in the service of survival; self-preservation is primary. Modification of libidinal desire, Freud believes, is the best that can be hoped for under the guidance of the reality principle. The resolution of the oedipal conflict thus redirects sexual/libidinal energy in the service of the ego. This period not only marks the development of the superego, successful conflict resolution here enhances the domain of the reality principle.

Freud's thinking about instincts was always evolving, and therefore evokes a multitude of interesting questions about pleasure. At the end of *Beyond the Pleasure Principle*, he arrives at a view more complex than any previously stated, which foreshadows the work of modern neuropsychology and infant observation. He notes that feeling tension itself can be pleasurable or unpleasurable. He wonders if this is perhaps a problem of magnitude and otherwise a problem of bound versus unbound energy. Freud thought that emerging biological science would clarify our thinking. "Biology is truly the land of unlimited possibilities. We may expect it to give us the most surprising information and we cannot guess what answers it will return in a few dozen years to the questions we have put to it" (Freud, 1920, p. 60).

#### Modern Developmental Research

So is pleasure simply about the relief of tension? By 1920, Freud is beginning to think otherwise. Modern developmental research would argue that tension itself is more complex. In the view of Sroufe (1995), pleasure does modulate tension early in development. Tension itself, however, is not seen as displeasure. Tension or arousal in the infant exists as a neutral platform; it is an indication of the child's attention being captured by some stimulus in the environment. Sroufe (1995) does not see this as a drive

phenomenon. “Tension, as described here, is not always present and seeking discharge, and it is not necessarily aversive. Tension is a natural consequence of the infant’s engagement of novel stimulation” (Sroufe, 1995, p 92).

These are two very different theoretical orientations to the problem. Sroufe sees tension as an organic, organizing response to novelty. “In a secure context,” Sroufe states (1995, p. 92), “infants actively seek to reproduce incongruous, tension-producing situations.” Sroufe is arguing that tension itself is initially affect-neutral. The affect produced depends upon the result of the interaction between the environment and the infant. Tension or arousal is seen as an internal response that draws the infant’s attention to his or her internal and/or external environment.

Sroufe’s (1995) work would indicate that the assessment of a stimulus as novel and not dangerous takes place in a relational context. The safe context encourages the exploratory behavior of the infant, that is, the infant’s pursuit of engagement with the novel stimuli. Sroufe (1995) does not dismiss the need for the infant to manage potentially threatening circumstances. “Wariness, or hesitation and guardedness in the face of something unfamiliar, serves the function of protecting the human being from being harmed by a malevolent creature or situation” (Sroufe, 1995, p. 94). He does, however, draw our attention to both possibilities. New stimuli may be dangerous or they may be positively engaging. Tension is not purely negative, because while perhaps initially making us wary, it also draws us towards novelty, which is necessary for our development.

“The developmental value of transactions with novel and unknown aspects of the environment must also be emphasized. A major adaptive advantage of humans is

opportunism—capitalizing on new discoveries and taking advantage of novel occurrences. Also engaging novel situations enhances cognitive development” (Sroufe, 1995, p. 94). Sroufe goes on to differentiate between the infant in a secure attachment situation and the infant in an insecure attachment situation. “Following orienting and tension buildup in an insecure context, crying and active avoidance serve both goals . . . attracting the parent and . . . modulating arousal” (Sroufe, 1995, p. 95).

Sroufe is discussing the edge of emotional regulation. Any new stimulus, depending upon both its potential threat to the infant and the relational environment in which it appears, will move us closer to fear and danger or towards “pleasure in cognitive challenges” (Sroufe, 1995, p. 99). Sroufe is including in his cognitive challenges the infant’s elaboration of schemas for relating, which produce laughter between self and other. Tension may produce the possibility of relational, interpersonal pleasure.

Previous writing has referred to this phenomenon, positing that “positive feelings of excitement are critical not only to sexual arousal, but to all exploratory and risk-taking behaviors” (Migdow, 2003, p. 7). Theoretically, Sroufe is in agreement; tension or excitation is a capacity embedded in our endowment. Whether it becomes an uncomfortable or pleasurable experience depends upon both the stimulus itself and the environmental, relational context.

Many other developmental researchers concur. Tension regulation has been a key concept in infant research. Perry (2001, p.24) sees play as essential to the growth and development of children: “[T]he heart of play is pleasure.” Pleasure in Perry’s (2001, p. 25) thinking is also embedded in the right amount and type of stimulation. Thus, he

argues, “[S]ometimes it is the lack of external stimulation and solitude that facilitates creative play...the opportunity to be alone without too many external stimuli.”

Wolff (1987) has devoted an entire book to the question of behavioral state regulation and the expression of emotion. Stern (1985, p. 97) discusses the same phenomenon in terms of RIGs, or representations of interactions, which are generalized. Putnam (1997, p. 151–179) calls this process the regulation of discrete behavioral states. All are attempting to understand and conceptualize how an infant regulates within the context of a relationship and all concur with Sroufe (1995).

Affect regulation is seen in modern developmental research, from Emde (1991, 1999) to Schore (1994), as the keystone to well being. Too much stimuli is defined by the endowment of the particular baby, and his or her interaction within a particular relationship and the developmental stage. Too little stimuli also produces displeasure. The sense of well being within this literature, starting with Bowlby (1969, 1973, & 1980) and Ainsworth (1969), is dependent upon affect regulation and is expressed as the experience of the right amount and kind of stimulation within the context of a safe interpersonal environment. Might this be one definition of pleasure?

Bowlby himself (1969, 1973, & 1980) never addresses the issue of pleasure directly. In all three volumes of Bowlby’s monumental work, there are only four references to pleasure (1969, p. 16, p. 20, p. 146, & p. 156). Each is a brief reference to his disagreement with Freud that pleasure is the primary organizing principle in human behavior.

Holmes (1995, p. 25) argues that attachment theory as elaborated, since Bowlby (1969, 1973, & 1980) downplays the role of infant sexuality and sees that “pleasure is related

to proximity, play and nurturance rather than orgasmic discharge.” This view is a radical departure from Freud’s early premise that tension is a source of unpleasure.

The idea of pleasure as being a secondary derivative of object seeking originates in the literature with Fairbairn (1944/1952), who contrasts his view to the classical Freudian position in declaring that libido is object seeking. In Fairbairn’s (1944/1952) view, the infant seeks objects or others upon whom he is dependent for the satisfaction of his needs. Thus, in Fairbairn’s view, to be primarily pleasure seeking is a perversion, a substitute for the primary need for objects.

In fact, Fairbairn (1944/1952, p. 83) says Freud made a similar point himself in *Civilization and Its Discontents* (1930) in stating, “Love seeks for objects.” Freud (1920, p. 50) also makes this point in *Beyond the Pleasure Principle* when he states that “sexual instincts are directed towards an object.” Hence, successful resolution of the Oedipus complex redirects sexual instinct and libidinal energy from the autoerotic preoccupation with the self towards the object-seeking other.

The argument between Fairbairn and Freud could thus be understood, in part, as a question of the primacy of development. Are all children innately primarily pleasure seeking, or are we all from birth primarily object seeking?

### Kohut and Self-Psychology

Before Kohut (1966) began to formulate self-psychological theory, he clearly concurs with Freud’s primary definition of pleasure. “Pleasure is experienced when psychological tension is relieved or when such relief is anticipated shortly” (Kohut and Levarie, 1950, p. 73). In his early formulation, he diverges from Freud in seeing the

regulation of tension as relational and hence healthy development moves from autoeroticism to the cathexis of narcissistic libido through optimum age-appropriate mirroring of the grandiose self within the context of an idealizable other (Kohut, 1971). When optimal development proceeds the individual build psychological structure, this creates a cohesive self. This self is able to maintain equilibrium within the context of its self and its relationships.

In his later formulation of self-psychology (1977), Kohut turned away from the drive theory of tension regulation. Tension regulation is preserved in Kohut's model with these modifications. Tension regulation takes place as a relational phenomenon beginning at birth and proceeding throughout life.

Hence, we all need each other throughout life to support our sense of self-worth and secure our self-esteem. For Kohut, perversions were a type of regression to autoeroticism, consisting of obsessive pleasure seeking arising from fragmentation in the face of empathic failure. This is an attempt to manage disintegration anxiety.

Though Freud (1920) discusses multiple sources of pleasure in *Beyond the Pleasure Principle*, including repetition, novelty, and the restoration of equilibrium, neither Freud nor Fairbairn address the possibility that we may be both pleasure seeking and object seeking from birth. A recent study by Barna and Legerstee (2005, p. 65) indicates "that at birth infants come prepared to interact with people. Through these interactions, infants *construct* progressively refined understandings that lead to an awareness, before the end of the first year, of people as intentional agents that will act on the things they want" Barna and Legerstee (p. 64) contend that "the experimental data not only indicate that infants have a preference for Happy over Unhappy faces," but

additionally that infants are using emotional valence to predict the behavior of others. The happiness or unhappiness of others thus becomes information of import to the developing child.

Questions arise from the preceding literature. Perhaps both our movement towards pleasure itself and the thrust toward object seeking are primary? Perhaps pleasure has both the potential to relieve our distress and enhance our life experiences? These questions are addressed both by the current developmental literature previously cited and the modern neuropsychological literature to date.

## The Neurobiology of Emotion

### *Definitions*

Panksepp (1998, p. 182), in discussing the neurobiology of pleasure, starts his definition of pleasure “with the supposition that pleasure indicates something that is biologically *useful*.” He adds that “it has been experimentally affirmed that pleasant and unpleasant feelings provoked by external stimuli arise from their ability to predict bodily imbalances” (Panksepp, 1998, p. 182). Since useful stimuli are defined as “those that inform the brain of their potential to restore the body towards homeostatic equilibrium,” Panksepp’s (1998, p. 182) definition of pleasure is most closely understood as homeostasis. Related to this definition of pleasure may also be the activation of any of a number of positive affect states individually or simultaneously.

This leads not only to the complex problem of the differences between biological and psychological definitions, but also to the problem of how we define affect or emotion or feeling itself. Biologically, Panksepp (1998, p. 41) argues that “a limited number of powerful primary emotional circuits—those that appear to elaborate fear, anger, seeking,

and sorrow—have been sufficiently well characterized to be addressed by brain research.” Panksepp goes on to state that other systems are less well known, and additional systems may be mixtures of the primary system.

Tomkins (1963) described nine universal biologically available emotions based upon facial expression: interest-excitement, enjoyment-joy, surprise-startle, fear-terror, distress-anguish, anger-rage, shame-humiliation, dissmell, and disgust. In this categorical approach, joy is the emotion most closely related to the concept of pleasure. Panksepp’s (1997) paradigm also relies on the categorical approach and begins to posit the neurobiological underpinnings of emotions as “they arise from genetic dictates.” He states that “they mold and are molded by experience throughout the life span” (Panksepp, 1998, p. 42).

Panksepp (1998, p. 48) defines emotions as “the psychoneural processes that are especially influential in controlling the vigor and patterning of actions in the dynamic flow of intense behavioral interchanges between animals, as well as with certain objects during circumstances that are especially important for survival. Each emotion has a characteristic feeling tone.” Hence, in Panksepp’s (1998) model there are four major emotional systems, each of which is genetically predetermined and each of which has a unique feeling tone. Emotion delineates a prewired circuit that organizes behavior, while feeling is defined as the affective component of the circuit. According to Panksepp (1998), there are a number of features of these systems that are of import. These systems are genetically predetermined; they organize behavior; they have reciprocal interactions with other brain regions, which organize higher thought and consciousness; and they are environmental affected.

Thus, Panksepp's model not only biologically defines emotion, it also describes emotion as mediated by reflective thought and conditioned by environmental stimuli. Therefore, endowment, environment, and the individual's reflective capacities all are seen as essential elements in the creation of a felt state of being.

Panksepp's (1998) thinking interfaces with the modeling of emotional systems proposed by LeDoux (1996, p. 19), who defines feelings as conscious states of awareness that "are in one sense no different from other states of awareness, such as the awareness that the roundish, reddish object before you is an apple." Hence, feelings require some reflective capacity. In LeDoux's (1996, p. 102) model, emotions are "functions involved in survival." LeDoux (1996, p.19) sees emotions as unconscious processes: "emotions are things that happen to us rather than things we will to occur." Because emotions are seen as seated in evolutionarily derived survival systems, that is, "defending against danger, finding food and mates, caring for offspring," LeDoux (1996, p. 103), like Panksepp (1998), theorizes that different emotions will involve different brain systems for different functions.

Damasio (1999, p. 42) proposes "that the term feeling should be reserved for the private, mental experience of an emotion. The term emotion should be used to designate the collection of responses, many of which are publicly observable." He is making a parallel observation between self-reflective capacity and biologically driven states often existing outside of awareness.

In Damasio's (1999) nomenclature, the embodied portion of our affective experience that can become observable to others defines emotions, while the portion of that experience that belongs privately to the individual becomes the definition of a

feeling. Panksepp's (1998, p. 48) concept of "feeling tone" is comparable to Damasio's definition of feeling.

Solms and Turnbull (2002, p. 111) summarize this definition of emotions by stating that:

[T]he motor aspect of emotion involves both inwardly and outwardly directed discharge processes. Inwardly, the experience of emotion is accompanied by the release of hormones, changes in breathing, and heart rate, vasodilation and vasoconstriction, changes in regional blood supply. Outwardly, emotion manifests itself in various ways: through changes in facial expression, baring of teeth, crying, blushing . . . also in complex behavior like shouting, running away, and lashing out.

### *Emotional Processing*

Largely following Panksepp's (1998) model of emotion, Solms and Turnbull (2002, p. 91) expand his discussion of the connection to higher brain regions by suggesting that perception of emotions is "the function of consciousness." They argue that consciousness, which arises out of higher brain functions, is both introspective and evaluative. Hence, how emotions are experienced is also a neurobiological process. "They make us want to do something" (Solms & Turnbull, 2002, p. 111).

This statement is entirely consistent with the arguments of Panksepp (1998), LeDoux (1996), and Damasio (1994, 1999); emotions serve a function. Emotions are "operating systems" designed to help the human being learn about and make useful adaptations to the environment (Panksepp, 1998, p. 49). Panksepp (1998) delineates four primary and three secondary emotional systems: the primary systems are SEEKING, RAGE, FEAR, and PANIC and the secondary systems are LUST, CARE, and PLAY. Not only is the SEEKING system pivotal to any discussion of the neurobiology of

pleasure, all three secondary systems are critical to the elaboration of distinctive experiences of pleasure.

Damasio (1994) also differentiates between primary emotions, secondary emotions, and background emotions. Damasio (1994) uses Tomkins' (1963) formulation that primary emotions are prewired at birth. He defines secondary emotions as those that are dependent upon the individual's unique developmental experience and only "occur once we begin experiencing feelings and forming systematic connections between categories of objects and situations on the one hand, and primary emotions on the other" (Damasio, 1994, p. 134).

Finally, Damasio (1994, p. 150) adds a third category of emotions, which he defines as "background feelings." These feelings are representations of "body states which occur in multiple somatosensory cortices in the insula and parietal regions, and also in the limbic system, hypothalamus, and brain stem." The literature on the neurobiology of emotion consistently reports such complex interweaving of biological pathways (Damasio, 1994, 1999; LeDoux, 1996, 2002; Panksepp, 1998; Schore, 1994, 2003; Solms and Turnbull, 2002).

Pally (1998, p. 350) summarizes the literature by defining the neurobiology of emotional processing as "a constellation of (a) stimulus appraisals as their relevance to the organism, (b) brain and body changes that result from those appraisals, and (c) feedback from the brain itself of those brain and body changes." Her discussion of all three arenas is relevant to both definitions and understandings of the neurobiological processing of pleasure.

In discussing the appraisal of stimuli, Pally (1998, p. 350) separates out what she defines as rewarding versus aversive stimuli, stating, “[W]e tend to have positive emotions (that is, happiness) about rewarding stimuli.” Simple stimuli, according to Pally (1997, p. 350), are appraised as negative or positive by the amygdala and, if more complex, then by the orbitofrontal cortex, which requires information “built up from personal experiences over the course of one’s life.”

Certainly, LeDoux (1999) would concur that the job of the amygdala is that of gatekeeper, assessing stimuli for signs of potential danger and activating the body accordingly. If a stimuli is not considered dangerous or, in Pally’s (1997) language, “aversive,” it does not necessarily mean that it is pleasurable. The appraisal of the stimuli as not aversive allows only for the possibility of it being experienced as pleasurable.

Pally defines (1997, p. 351) the “brain and body changes which result from those appraisals” as trifold: “endocrine production, autonomic nervous system responses, and musculo-skeletal behaviors.” In the realm of positive emotion regulation of cortisol, levels are key. Several researchers report that innate abilities to self-soothe vary. “Healthy babies react to stress with a rise in cortisol, but then can automatically use quiescence to recover from stress and reduce cortisol” (Pally, 1998, p. 356; Gunner, 1992, Porges, 1992). The research indicates that regulation of cortisol may be a key component for a sense of well being. A multitude of researchers have implicated cortisol dysregulation as a response to traumatic experience (Gunner & Donzella, 2002, Gunner & Vazquez, 2001; Porges, 1997; Yehuda, 1999; Yehuda & Flory, 2007; Yehuda, Macfarlane, & Shalev, 1998).

### *Pleasure*

Pleasure can be understood neurobiologically as the achievement of bodily equilibrium through the activation of any of several brain systems that are associated with positive affect. Panksepp (1998, p. 182) urges the need for a scientific definition of pleasure: “a general scientific definition of the ineffable concept we call pleasure can start with the supposition that pleasure indicates something biologically *useful*.” In this theoretical model, getting biological needs met is useful; therefore, positive affect is associated with both energized exploratory behavior and the satisfaction of getting what is needed. This is the job of the SEEKING system. Because this system is energized by need, he sees it as inextricably bound with intense interest, eager anticipation, and engaged curiosity.

### *The SEEKING System*

Panksepp (1998, p. 145) states the hypothesis that “the mammalian brain contains a ‘foraging/exploration/investigation/curiosity/interest/expectancy/ SEEKING’ system that leads organisms to eagerly pursue the fruits of their environment.” He goes on to define this system as an emotional system that “has a characteristic feeling tone—psychic energization...akin to that invigorated feeling of anticipation we experience when we actively seek thrills and other rewards” (Panksepp, 1998, p. 145). This begins a discussion of some of the complexities of the reduction of distress, regulation of overwhelming or noxious stimuli, as well as the production of excitement.

According to Panksepp (1998, p. 164), “[M]ammals can survive only if they maintain relative constancy of various bodily processes.” Homeostasis is thus critical to

human well being. The body needs a variety of fuels, such as oxygen and nutrients, to survive and a variety of stimulation for the growth, development, and maintenance of brain function. Most of what is needed, Panksepp (1998, p. 168) argues, must be sought; the neurological “SEEKING system is well situated to be influenced by an array of bodily needs.” The SEEKING system responds to internal and external stimuli by activating movement towards the environment through exploratory behavior.

“Neuroanatomically, the SEEKING system corresponds to the major self-stimulation system that courses from the midbrain up to the cortex, which has long been misconceptualized as a ‘reward or reinforcement system’” (Panksepp, 1998, pp. 53–54).

While Panksepp (1998, p. 168) argues that much is still not known about the neurological underpinnings of this system, knowledge about the relative need for more or less energy “appears to be achieved in large part through specialized cells in the medial and lateral zones of the hypothalamus. This system has two components. First, it energizes animals to move forward in search of what they need. This seeking behavior is predominantly promoted by the neurotransmitter dopamine, which promotes psychomotor and motivational focus and arousal (Panksepp, 1998, p. 107). The second aspect of this system is consummatory. Satisfaction is obtained. The animal gains the fruit of its desire. This part of the process activates the opioid system (Panksepp, 1998, p. 184).

Though Panksepp (1998, p. 164) argues “energy is delight,” he thinks the preponderance of evidence indicates that in understanding the neurochemistry of pleasure, “if one contrasts data on the opioid and dopamine systems it is clear that a role for opioid components presently has the most empirical support” (Panksepp, 1998, p.

184). The neurochemical data connecting pleasure with satisfaction is hence greater than the data connecting pleasure with seeking. This argument again poses the problem of a definition of pleasure. Panksepp (1998) uses the term to discuss neurobiologically both exploratory and consummatory behaviors. This leads back to the discussion of tension regulation and how individuals define and experience pleasure. Are some more delighted by the chemical wash of the energizing dopamine system? Are others more content with the consummatory pleasure of the opioid system? Under what conditions do individuals find either pleasurable? In addition, as Panksepp (1998, p. 185) points out in the instance of food regulation, pleasurable is not always useful. There is much about the psychoneurology of eating that is not understood. Why do some people develop significant problems with food regulation? Why is their experience of pleasure not useful to maintaining their well being? Why do some become anorexic, bulimic, or obese?

### *The LUST System*

Herein Panksepp (1998) takes on the task of delineating and differentiating the stages of human sexual arousal in men and women and defining the neurochemistry of sexual pleasure. Panksepp (1998, pp. 242–243) posited the question: “[W]hat does it mean, in neurochemical and neuropsychological terms, to have experienced sexual pleasure?” He concludes that no definitive answers yet exist, while a multitude of neurochemicals seem to play some part.

“Although brain oxytocin and vasopressin circuits are excellent candidates for organizing both the behaviors and the emotional feelings associated with sexuality, they are only two of the most prominent candidates in a growing list of chemistries that

elaborate libido” (Panksepp, 1998, p. 243). There are reports that sexual performance can be enhanced by intranasal oxytocin (Fehm-Wolfsdorf & Born, 1991). Still, sexual performance is not the same as sexual pleasure. Additionally, physiological markers of orgasm, which denote somatosensory arousal, may or may not be defined by individual subjects as experiences of pleasure.

Panksepp’s (1998) discussion does not begin to approach the great complexity of human sexuality and the variants that individuals experience as pleasurable. Freud (1905/1953) discussed the enormous plasticity of human sexual behavior and experience. The neurophysiology of arousal is not an answer to the question of how variant sexual behaviors become arousing to any particular individual.

### *The PLAY System*

Panksepp (1998, p. 280) defines the PLAY system as “the brain sources of joy” and uses a body of research with rats to conclude that “although our knowledge about the underlying PLAY system remains rudimentary, RAT play appears to be intimately linked to somatosensory information processing within the midbrain, thalamus, and cortex.” He distinguishes this circuit from both the RAGE system and its attendant aggression and the SEEKING system. Panksepp (1998) notes the importance of this differentiation as exemplified by the fact that the SEEKING system and the PLAY system can operate either synergistically or antagonistically.

Exploratory behavior in search of needed bodily supplies can pre-empt play directed at social interactions, while stimulation of the SEEKING system can increase “object or manipulative play” vital to increasing knowledge about the environment

(Panksepp, 1998, p. 296). He postulates that over or under arousal of the PLAY system may lead to psychiatric conditions of mania, depression, and other impulse disorders, such as attention deficit with hyperactivity already correlated with problems in cortical functions (Panksepp, 1998, p. 297). While Panksepp (1998, p. 297) postulates that “it could still be the case that a major adaptive function of play is simply the generation of a powerful positive emotional state,” others argue that play itself functions as both an outgrowth of secure attachment and a ground for seeding affective regulatory function. Sroufe (1997, p. 215) says, “[F]antasy play is a major tool for emotional regulation.”

Rosenberg (1984) found that children with secure attachment histories had more flexibility, complexity, and creativity in their play, showing a greater range of emotional themes. These arguments indicate possible overlaps between Panksepp’s (1998) PLAY system and CARE system.

### *The CARE System*

Panksepp (1998, p. 246) defines the care system not only by its implications for social bonding, but also says “the nurturant circuits in the mother’s brain and care-soliciting circuits in infants are closely intermeshed with those that control sexuality in limbic area of the brain.” The CARE system, the LUST system, and the PLAY system can now be seen as deeply, neurologically intertwined.

Panksepp (1998, p. 249) defines the CARE system as “the intrinsic brain systems that promote nurturant behaviors of mothers, and occasionally fathers, towards their offspring.” Panksepp (1998, p. 253) states that the neural circuitry of “full maternal behavior extend far and wide in the subcortical regions of the brain.” This conclusion

comes from rat research, which shows the reception of sensory stimuli in the dorsal preoptic area (POA) of the hypothalamus and the ventral bed nucleus of the stria terminalis (VST) is passed onto many areas of the brain, including the medial hypothalamus (MH), the ventral tegmental area (VTA), the periaqueductal gray (PAG), the habenula (HAB), and the septal area (S) (Panksepp, 1998, p. 253–255).

Panksepp (1998) is thus locating the neural circuitry of maternal behavior deep in the oldest physiological and emotional regulatory systems in our brain. He locates these systems in the basal ganglia (VBN, VTA, and PAG), the limbic system (POA, MH, and HAB), and the neomammalian brain (S) parts of our brain.

“Oxytocin influences may be essential for engaging specific motivational circuits for maternal behavior, such as sensitivity to affective responses” (Panksepp, 1998, p. 254). The neurochemical most implicated in relieving separation distress is in the opioid system (p. 255). Both have relevance for affect regulation. Oxytocin promotes better attunement to others’ affects, while opioids mediate distress at disruption.

### *Neurobiology Summary*

Panksepp (1998, p. 182) urges the need for a scientific definition of pleasure; “a general scientific definition of the ineffable concept we call pleasure can start with the supposition that pleasure indicates something biologically *useful*.” We can wonder, neurobiologically, might pleasure best be seen as a substrate of the SEEKING system? Additional possibilities exist. Panksepp’s (1998) CARE system presents us with a distinctive route to pleasure and a further complication when embedded in the environmental circumstances of interpersonal trauma and neglect within the dyadic

relationship of child and caretaker. As the possible functions of play have been discussed extensively, we might wonder about the implications for development if opportunities for play are foreshortened by the imperatives of survival mandated in situations of childhood abuse and neglect. To further compound this problem, playful overtures and engagement of children by pedophiles may activate both PLAY and LUST sensory systems, inducing a neurobiology of pleasure, which is at odds with others' feelings of anxiety and alarm simultaneously aroused in the FEAR system by the perception of danger (Panksepp, 1998, pp. 50–54). Further thinking by Schore (1994, 2003) on affect regulation will be discussed later, but for now, we can posit that cortisol levels could be one of the markers of Damasio's (1994, p. 150) "background emotions," which indicate an overall state of well being or disruption. Individual differences in reactivity to stress that allow for a more or less resilient cortisol response when faced with a traumatic event may have implications for the ability to retain the capacity to experience pleasure (Yehuda, 1999).

### *Neurobiological Substrates of Affect Regulation*

Schore's (1994, 2003a, 2003b) theory of affect regulation, while accounting for the many elements of both Panksepp's CARE and PLAY systems, holds a more localized view of the neurobiology involved. Schore (1994, p. 309) argues that when the mother provides early cross-modal stimulation, experience-dependent maturation occurs in the orbitofrontal cortex of the infant. Schore (2003) sees this region as pivotal to affect regulation and specifically implicates the right orbitofrontal cortex in affect regulation.

He argues that the right hemisphere predominantly controls executive function; the right hemisphere has a faster ability to detect emotional valence and read nonverbal

affect through facial expression, gestures, and tone. The right hemisphere also contains more extensive connections with the limbic and subcortical regions. For all these reasons, he concludes that “the co-created environment of evolutionary adaptiveness is thus isomorphic to a growth-facilitating environment for the experience-dependent maturation of a regulatory system in the (right) orbitofrontal cortex” (Schore, 2003, p.60).

His hypothesis proposes “that the growth, maturation and functional onset of this prefrontal psychobiological structure underlies the emergent psychological affect regulatory function which evolves in the critical period of primary socialization of infancy, the practicing period (10–12 to 16–18 months)” (Schore, 1994, p. 57). Schore’s (1994) thinking is consistent with the thinking of Sroufe (1997), who defines pleasure as an emotional system of evolving developmental complexity that begins with the social smile and expands within the context of secure affect regulation.

LeDoux’s (1996) primary condition for the definition of an emotion is that it does something biologically useful. Panksepp’s primary condition for a definition of pleasure (Panksepp, 1998, p. 182) is the same. If affect or tension regulation is a necessary biological process, then affect regulation must also do something biologically useful.

Interestingly, this notion collides with Schore’s idea (2003) about what happens in traumatic dissociation, wherein he argues that the orbitofrontal region fails in the face of traumatic dissociation. “This would lead to a deactivation of every component of Panksepp’s (1998) system of prototypic affective states” (Schore, 2003, p. 136). Schore (2003) is arguing that the biological need for dissociation in the face of certain traumatic events trumps all of Panksepp’s emotional systems, implying that *nothing* is felt at the moment of dissociation. In this emergency, Schore (2003) reasons, shutting down all

emotional systems meets a biological need. Pleasure and positive affects may then not always be embedded in the meeting of a biological need; they may, in fact, be completely absent in the face of some of our most pressing survival needs.

A recent study done by Tull (2007, p. 303) supports the hypothesis that “overall difficulties with emotional regulation were associated with PTS (posttraumatic stress) symptom severity.” In this study, subjects with symptoms meeting the criteria for PTSD reported greater difficulty with emotional regulation. In one of the largest studies to date of how child abuse, adult rape, and social support affect inner city women, Schumm, Briggs-Phillips, and Hobfoll (2006) found that social support may buffer interpersonal trauma. Social support may assist affect regulation, even in the face of overwhelming assault.

### *Integrative Summary*

If, neurologically, interpersonal learning is activating schemas that are grounded in the discrete emotional systems, as defined by Panksepp (1998), it might be expected that the neurobiological wiring of pleasure would be not only individual, but also malleable and open to idiosyncratic variations—not only in sexuality, as described by Freud (1905/1953), but in other areas of pleasure. Perry (1995, p. 271) has proposed that the “neurobiology of adaptation,” under the ongoing assault of traumatic stimuli, pushes neurobiological states intended for flexibility into fixated neurobiological traits potentially hazardous to the individual’s well being and further development. This proposal argues that even such hardwired emotional systems as those proposed by

Panksepp (1998) are deeply impacted by environmental factors. LeDoux's (1996) research on fear comes to the same conclusion.

In LeDoux's (1996) schema, tension precedes fear. Tension is not fear. Tension, in this frame of reference, awakens the orienting response (LeDoux, 1996, p. 131). This idea is similar to Freud's concept of signal anxiety (Freud, 1920). This is also the same argument that Sroufe (1995) is making. If danger is perceived, we move into fear, one form of displeasure, and avoidance of the stimulus if possible. However, if the stimulus is perceived as not dangerous, we process this information biologically along the "high road" (LeDoux, 1996, p. 164).

This trajectory allows for more complex and time-consuming cortical functioning, reflection, and—again—exploratory activity. This response is reported in all animals and is thought to be part of our innate makeup derived from evolution for the sake of individual and species preservation.

The animal orients itself to the novel stimuli first, LeDoux (1996) would argue, to assess the threat. If we perceive a threat or feel fear, our brains process this information through the "low road" (LeDoux, 1996, p. 164). The low road is the fast route in a brain intended to mobilize us quickly and physically, so that we might act protectively in the face of danger.

Additionally, the proposition that a safe context embedded in a secure attachment is fundamental to the experience of pleasure is further elaborated upon in the work of Csikszentmihalyi (1990). Excitation paired with exploratory behavior within a safe context is at the roots of Csikszentmihalyi's understanding of positive affect. His research

is concerned with optimal affective experience and explores the components of what he found was necessary to this experience.

Flow is Csikszentmihalyi's word for the optimal experience. He defines flow as the experience in which "concentration is so intense that there is no attention left over to think about anything irrelevant or to worry about problems" (Csikszentmihalyi, 1990, p. 71). While not denying that other forms of positive affect exist, he argues that his research interviews indicate that the best moments are moments where we are stretched to the limits of our capacities by our active and voluntary pursuit of that which compels our interest.

Tension is again a key component here. Csikszentmihalyi's (1990) definition of pleasure is not embedded in the relief of tension. For Csikszentmihalyi (1990), as for Sroufe (1995) and LeDoux (1996), tension does not equal unpleasure. Tension is seen as a necessary component of at least a certain form of pleasure, exploratory pleasure, which he calls enjoyment.

This brings forth further questions. How primary in development is pleasure? Is pleasure an organizing principle?

Bowlby (1969) argues that proximity is the organizing principle. Sroufe (1995) argues that tension is a primary organizing principle. For Wolff (1987), state regulation is primary. Schore (1994, 2003) proposes that affect regulation is the seat of secure attachment. These are all ultimately interpersonal theories that privilege the human emotional relationship as primary to the well being of the infant.

Kohut has essentially made the same argument. In his seminal paper, Kohut (1982) for the first time expands his conceptualization of empathy beyond his original

definition as a value neutral mode of observation and information-gathering activity. He now states that empathy is also an essential nutrient that sustains life. “Empathy is thus a precondition for a mother’s appropriate functioning as the child’s self-object” (Kohut, 1982, p. 67). He goes on to say that “empathy *per se*, the mere presence of empathy, has also a beneficial, in a broad sense, a therapeutic effect—both in the clinical setting and in human life in general” (Kohut, 1982, p. 67).

Is empathy then a necessary precondition for pleasure? Kohut does not say. We do feel pleasure in empathy alone, Kohut (1982) postulates. He goes on to say that his hypothesis is that “the fear of death and the fear of psychosis are, in many instances, the expression of the fear of the loss of the empathic milieu” (Kohut, 1982, p. 398).

Is pleasure primary to development? The beginnings of this possibility are indicated in at least two distinct ways. First, if affect regulation takes place in the context of “affect attunement” (Stern, 1985, p. 138–161) and empathy (Kohut, 1982), then this context may be a necessary precondition for the possibility of pleasure. Second, if the infant held in Sroufe’s (1995) safe context moves towards novel stimuli, *towards tension*, then the hypothesis that pleasure seeking in the form of seeking new and ever-more complex and elaborated interactions with our environment could be an innate characteristic. If this is not an instinct, it may at least be part of our genetic endowment, which increases the likelihood of the survival of the species.

Recent theorizing in anthropology supports this hypothesis. In his 2006 lecture at the Field Museum in Chicago, Dr. Robert Martin stated that the most recent work in anthropology now reveals that, after surviving for 200,000 years, the Neanderthals (*Homo neanderthalensis*) were not killed off because of the ice age. Anthropologists now

posit that their extinction was due to their inability to compete for resources with our ancestors (*Homo sapiens*).

The Neanderthal brain was not well suited to manage novel stimuli. Our genetic ancestors competed with the Neanderthals for environmental supplies and were better suited to exploration. Because of our innate curiosity, we moved towards novel stimuli. So, perhaps in moving towards novel stimuli, our idiosyncratic genetic endowment pulls us not just towards novelty, but towards particular aspects of our environment. This pull towards particular stimuli might be a pull towards that which we experience as pleasurable. Further, it is possible to hypothesize that a secure base, provided by the safety created in an empathic milieu, makes it possible to pursue our individual pleasure, optimally with the depth, intensity, and complexity that Csikszentmihalyi (1990) believes is necessary to flow.

Sroufe's (1995) evidence is that tension is not a pure good or a pure bad. Tension in response to novelty, though individually variable, is normative. We have tension when in distress, but we also have tension that precedes new experience and exploratory behavior. So pleasure seeking may be an innate capacity that is organized by being held in good enough relationship. This capacity may allow us to seek out and explore new experiences that delight us. Part of what delights us is the good enough object, the other who empathically holds us. We might now wonder what happens when one or both of these processes are foreshortened by life experience.

Other questions emerge from this discussion. What interferes with the individual's capacity to experience pleasure? Particularly, what interferes with one's capacity to experience pleasure that is free of harm to self and others? Based upon the

literature reviewed, we might conjecture that the capacity for pleasure is often disrupted by an environmental context in which chronic, traumatic, empathic failure is normative.

Freud (1915) and LeDoux (1996) and Bowlby (1969) all speak to the primacy of survival. When our brains detect danger, we neurologically prioritize evasive or defensive activity. In Freudian terms, this is the pleasure principle ceding the ground to the reality principle. For Bowlby (1969), this is the infant organizing primarily to keep near the caretaking parent. The research of Ainsworth (1969), Main (1980), and Lyons-Ruth (1996) all indicate that children will make particular adaptations that foreshorten their exploratory behavior in order to adapt to the relational parameters of psychic proximity set by their primary caretakers.

If survival responses trump all other possibilities, perhaps the “fear reaction system” precludes pleasure (LeDoux, 1996, p. 165). He argues that “the direct pathway allows us to begin to respond to potentially dangerous stimuli before we fully know what the stimulus is” (LeDoux, 1996, p. 164).

Additionally, he proposes that we are prewired by evolution to have both “natural triggers” and the capacity to develop “learned triggers” (LeDoux, p. 127). Natural triggers are those stimuli that evolution has determined are dangerous to the species. Learned triggers rely on higher cortical functions that are dependent upon our individual ability to assess what in our environment may be associated with our natural triggers.

If, in the face of these triggers, there is no empathic response, the internalization of the capacity to self-soothe would be delimited. Angold et. al. (2000) address this problem in their research. They have found, as part of their longitudinal studies of traumatized children in the Appalachian Mountains, that among children showing the

acute symptomatology of PTSD, an empathic response from their mothers mediates the effects and they do not go on to develop chronic PTSD symptoms.

Empathy mediates the fear reaction. However, if the natural trigger itself is the primary caretaker turned predator, the child is clearly in even more of a dilemma. Not only is empathy unavailable, there is no escaping the primary source of distress. The implications for the development of problems with pleasure are multifold.

Any stimulus in the environment at the moment at which a natural trigger occurs can become associated with the natural trigger itself. Therefore, when our brain moves into the fear reaction system in response to the natural trigger, we may develop a learned trigger, a fear response to almost anything. Potentially pleasurable stimuli could become associated with fear, inducing either an avoidance response of flight, or a mastery response of fight. Excitation itself—tension—may become a noxious stimulus in an unsafe environment.

Unfortunately for trauma survivors, many of life's pleasures may be deeply intertwined with excitation and noxious stimuli, the triggering of which will quickly dampen sexual arousal, curiosity, and exploratory forays into new intellectual, emotional, or physical territory. "Flow" would become, at best, problematic, at worst impossible, given that by definition "such experiences are not necessarily pleasant at the time they occur" (Csikszentmihalyi, 1990, p. 4).

Could some people become pleasure avoidant? Could others become addictively engaged in reenactment? Could the repetition compulsion (Freud, 1920) be an attempt to master both interpersonal negative stimuli and learned extrapersonal triggers? Do patients

experience their psychotherapy as addressing and/or alleviating their problems with pleasure? If so, how does theory help us explain what patients' report?

### The Literature on Resilience

The literature on resiliency gives us some indications of where the solutions to these problems might be found. The study of protective factors that lead to resiliency has been of interest to researchers, theorists, and clinicians at least since Viktor Frankel's post-Holocaust account of survivorship in *Man's Search for Meaning* (Frankel, 1959). Frankel said, "Yes a man can get used to anything, but do not ask us how" (Frankel, 1959, p. 30).

Having made this statement, he goes on to discuss many factors that sustain those in dire circumstances. These include hope, curiosity, compassion, human connection and identification, religious practice and spiritual belief, remembrance of ordinary positive experience, heightened attachment to beauty and art, the capacity for humor, and the ability to find great joy in trifles and small reprieves. Putnam (1997, p. 263) also comments on the extraordinary resilience that children often display. "[D]espite trauma and loss, many youngsters exhibit a remarkable natural capacity to restore order and function in their lives."

This capacity has been seen as consisting of a natural invulnerability (Anthony & Cohler, 1987) that may emerge from a variety of protective factors (Rutter, 1987; Davidson, Hahar, Lawless, Sells, & Tondora, 2006). These factors have been categorized as a triad constructed of social resources (Mrazek & Mrazek, 1987; Long & Valliant, 1989; O'Connell-Higgins, 1994; Schumm, Briggs-Phillips, & Hobfoll, 2006), familial attributes (Wyman, Cowen, Work, & Parker, 1991; Demos, 1989; O'Connell-Higgins,

1994), and individual psychological strengths (Mrazek & Mrazek, 1987; Rutter, 1987; Demos, 1989; O'Connell-Higgins, 1994; Cicchetti and Cohen, 1995).

Higgins, in her study of resilient adults, notes that they “cultivated progress” (1994, p. 319). This faculty goes beyond those resources that one does or does not have in the environment. In a similar vein, Putnam comments that “the first crucial ability is the child’s capacity to take an active stance towards obstacles and problems.” “Resiliency is the capacity to bounce back, to change things for the better, to persevere despite difficulties—requires by definition the child’s persistence in trying to improve the situation” (1997, p. 264).

Beyond genetic endowment, poverty, and racism (Putnam, 1997) and familial characteristics (Demos, 1989), health, education, social welfare, and community resources (Mrazek & Mrazek, 1987), all the aforementioned authors emphasize the critical importance of individual capacities. We may infer that the nurturance of these capacities is fundamental to both functionality and the restoration of the self.

Lam and Grossman (1997, p. 190) pursued the investigation of protective factors in the lives of adult women, with and without reported histories of child sexual abuse. They found that “women with more of the composite of protective factors in fact were doing better in their lives, regardless of whether or not they had self-reported histories of childhood sexual abuse.”

Interestingly, their composite of biological, personal, life, family, and social circumstances consisted of 16 protective measures and their research “confirmed that 13 of the 16 protective measures were not in fact distinct from each other” (Lam and

Grossman, 1997, p. 185). This finding leaves open to discussion: Which core features of protective factors impact resiliency?

Given that their “results confirmed and extended previous studies . . . which found that individuals with resilient characteristics were at greater likelihood for a wide variety of positive outcomes” (Lam & Grossman, 1997, p. 191), it behooves us to continue hypothesizing which of these factors may significantly impact treatment outcomes and how might this knowledge be integrated into clinical practice.

Yehuda and Flory (2007) have undertaken this task. Their research seeks to define research protocols for assessing the interrelationship between risk and protective factors that emerge in the literature on resiliency. Their concern is that explanations of resiliency may “underemphasize individual differences.” They believe that research designed for “better separation between universal and prototypic responses” may address these difficulties.

Ungar (2004) proposes that we need a constructionist theoretical perspective to begin to make sense of resiliency. He argues (Ungar, 2004, p. 341) that there is a “nonsystemic, nonhierarchical relationship between risk and protective factors that is characteristically chaotic, complex, relative, and contextual.”

In conclusion, such arguments might inform an exploration of how the problem with pleasure is exhibited in survivors of trauma, especially in those who have survived extreme chronic childhood abuse. If Frankel (1959, p. 55) is correct, then the capacity for “great joy in trifles” may be one critical factor in the healing of trauma survivors.

If resiliency and perseverance are supported by hope, then the capacity to

believe in a life in which pleasure, not pain, predominates is fundamental. Understanding why and how trauma survivors are often unable to experience pleasure may be critical therapeutic information. This information can focus treatment planning to create more effective interventions, which will nurture resiliency, unfolding the potential for pleasure and furthering the repair of fragmented lives.

Constance Dalenberg (2000) offers us an example of a qualitative study through which we might begin to answer some of these questions. In her study of countertransference in the treatment of trauma, Dalenberg (2000, p. 285) interviewed 84 people “who had completed psychotherapy related to trauma and who were willing to give feedback to professionals about what they found helpful and unhelpful.”

Participants were interviewed on the phone and in person for one to three hours following an interview protocol devised to explore their experience of the therapeutic relationship. By interviewing patients directly, Dalenberg (2000) was able to comment on their experience of the therapeutic process.

The question remains of how individual traumatized children—each with a unique endowment, living within an idiosyncratic caretaking environment—resolve the problem of survival and develop their own management of stimuli in the interest of preserving or disowning their capacities for pleasure. What is the role of psychotherapy in enhancing or restoring the capacity for pleasure in the adult patient who was reared in an environment of abuse and/or neglect?

## Clinical Theory Literature

A review of the psychoanalytic literature on pleasure shows little conceptual discussion of pleasure (Freud, 1920/1953; Kohut, 1950, 1977, 1978, 1982; Fairbairn, 1944/1952; Sroufe, 1995) and the related concept of affect regulation (Schoore, 1994, 2003). There has been some research with adults on the experience of pleasure (Csikszentmihalyi, 1990; Davidson, Shahar, Lawless, Sells, & Tondora, 2006; Lu, 1999).

Investigators have explored some related concepts. The Oxford Happiness Inventory (Argyle et al., 1989) is a 29-item measure of general subjective happiness. It covers three elements: positive affect, negative affect, and overall satisfaction with life. Schumm, Briggs-Phillips and Hobfoll (2006) have used a 10-item scale to measure social support. Cutrona and Russell (1987) have also investigated social support using the Social Provisions Scale. Social support is discussed in relationship to the impact upon resiliency. Resiliency is a concept often investigated (Anthony & Cohler, 1987; Higgins, 1994; Lam & Grossman, 1997; Wyman, Cowen, Work, & Parker, 1991).

The clinical theory guiding this research is defined by Mitchell's (1988, 1993) thinking about relational theory. Mitchell (1993, p. 67) argues that "on the level of clinical theory there has been a marked shift in emphasis from the clarification and renunciation of infantile fantasies to the revitalization and elaboration of the patient's sense of personal meaning. On the meta-theoretical level, there has been a fundamental redefinition of what psychoanalytic theorizing is, from a representation and reflection of the underlying structure of the patient's mind, to a construction, an interpretation of the patient's experience."

Mitchell (1988, p. 289) sees all relational theorists as starting from the same premise, that “the pursuit and maintenance of human relatedness is the basic maturational thrust in human development.” Mitchell (1988) then divides relational theory into two theoretical models. The first, self-psychology, posits a theory of developmental arrest and repair through provision. The second is relational-conflict theory, which emphasizes the child’s creation of a constrictive interpersonal world derived from what is available in early relationships. In the relational-conflict model, repair is found through reenactment and the co-creation of new relational experience.

### *Self-Psychology*

Mitchell (1988) traces Kohut’s theorizing from a drive-conflict model to a model of developmental arrest. He argues that self-psychology is a one-person theory, wherein therapeutic action is primarily unidirectional and developmentally reparative.

“Within the developmental arrest model, drive theory has been largely displaced, but some features of the approach to the past have been retained. Psychological time moves only if appropriate provision are supplied” (Mitchell, 1988, p. 149). Kohut says this a little differently. Kohut (1978, p. 928) argues that the self is restored through “structure building via transmuting internalization.” This is accomplished via interpretations that convey understanding and explanation of the patient’s experience.

This process can only take place in a therapeutic milieu that is psychologically neutral, that is, in an atmosphere free from gross psychological overstimulations and rejections. The analyst tries to be in empathic touch with the patient’s inner life at all

times, with the result that his failures are sufficiently small and of sufficiently short duration to allow the patient to respond to them via structure building.

Schore (2002) extends Kohut's clinical theory to problems of affect regulation. Schore (1993, 2003) sees problems with affect regulation as the core dilemma arising out of early trauma. Schore (2002, p. 455) argues that "instead of the optimal continuous dyadic reciprocal interactions with regulating selfobjects that maintain the infant's homeostasis...defensive dissociative responses embedded in relational trauma induce a severe failure of the infant's capacity to maintain metabolic-energetic equilibrium."

Schore (2002) believes that self-psychology offers a way to understand how this dysregulation happens and what might begin to affect repair. Schore (2002, p. 435) states that "perhaps Kohut's most original and outstanding contribution was his developmental construct of selfobject." He goes on to say, "[T]he selfobject construct contains two important theoretical components. The second component of the selfobject construct is the concept of regulation."

### *Relational-Conflict Theories*

Maroda (1998), a relational-conflict theorist, has a different application of Schore's (1993, 2003) research to clinical theory. She cogently argues that transparent emotional expression on the part of the clinician is neither an error nor a hindrance but is, in fact, a therapeutic necessity. Maroda (1998, p. 66) says, "[T]he mutually affective moment constitutes what is therapeutic between analytic therapist and patient."

Maroda (1998, p. 66) starts with Freud's contemporary, Vygotsky (1896–1934), the prolific Russian psychologist, who early on posited that "all psychological processes

appear first as an interpersonal and only later at an intrapersonal level.” This statement is the keystone to Maroda’s argument that when the patient does not know before entering therapy about affective regulation, it cannot be elicited from him or her, but it must be learned in the context of their experience of a mutually affective experience with their therapist.

Maroda (1998, p. 67) concludes that Stern’s (1985) research, along with that of Tronick (1979) and Demos (1980), demonstrates that the infant’s emotional development is dependent not only upon affect attunement, the matching of affect states between infant and caretaker, but also upon “interaffectivity,” the affect response by the caretaker to the infant’s emotional communication. This is congruent with Stern’s (2004, p. xiii) argument that “the basic assumption is that change is based upon lived experience.”

Maroda (1998, p. 79) also notes that “the uses of emotion are particularly important when treating patients who have suffered early trauma. Krystal (1988, 1997) has alerted us to the needs of patients he describes as alexithymic—those who cannot recognize or label or express emotions other than occasional outbursts of rage. He says these patients have typically been traumatized in childhood, causing them to develop into adulthood without the essential tools for expressing and containing emotions. Although the burgeoning literature on incest and other “survivors” seems to place great value on recalling past abuses, it seems that the more essential hurdle facing an individual who suffered early trauma is the identification, expression, and management of affect in the present.

Maroda (1998) argues that talking about feelings, as LeDoux (1994) tells us, is not the same as experiencing feeling. She concludes that feelings have been identified at

least since the time of Sylvania Tomkins (1962) to be both innate and social. The physical experience of a feeling, according to Maroda (1998), is necessary for new emotional learning; many feelings are social-relational rather than personal in meaning.

Therapeutic dyads continually monitor each other, registering shifts in affects and attempts to make meaning of what they are noticing, whether conscious or not. Given the history of clinical psychoanalytic thought on the necessity for analytic emotional control, Maroda (1998) notes, “[W]e have derived a clinical overemphasis on the containment of our more emotionally volatile patients, while largely ignoring the problems of our many more alexithymic patients, who the literature indicates are likely to have histories of severe interpersonal trauma.”

Maroda (1998) asks the question: How does change occur in the context of a therapeutic relationship? She argues that our clinical practice must be consistent with our burgeoning knowledge of emotional development and affect regulation. Maroda (1998, p. 81) asks, “How do you relate empathically to an unexpressed emotion?” Concurring with Schore (1994, p. 468) that “affect regulatory dialogs mediated by the psychotherapist may induce literal structural change” in the brain itself, Maroda (1998, p. 85) concludes that “it stands to reason that only new emotional exchanges could facilitate the altering of old affective patterns.” She posits that we can and perhaps must use our emotional responses constructively to engage the development of those same emotional capacities in our patients. “It stands to reason if emotional exchanges, or lack of, created the affective pattern that the person creates over and over again, then only new emotional exchanges could facilitate the altering of old affective patterns” (Maroda, 1998, p. 85).

Ehrenberg (1974, 1992) has been pursuing a clinical line of thought similar to Maroda's (1998). In her 1974 article, Ehrenberg (1974, p. 425) states that "in the analytic situation studying the moment to moment shifts in the quality of relatedness and experience between the analyst and patient permits exploration of individual patterns of reaction and particular sensitivities." She goes on to say (1974, p. 436) the essential qualities of the kind of engagement I am describing are *reciprocity* and *expanded awareness through authentic relation*. In speaking of trauma, Ehrenberg (1992, p. 17) says, "[P]articularly where patients have been severely traumatized, unless the analyst can establish that treatment can be of positive value, it is perfectly understandable that a patient may be resistant to risking yet another catastrophe."

Ehrenberg (1992, p. 52) thinks that thoughtful clinician self-disclosure can engage the therapeutic dyad in a process which creates, "for many patients, the opportunity to discover that it is possible to contain and deal constructively with aspects of experience that may have been feared, [constituting] an important form of *new experience*. This has healing potential in itself, and can become the basis for increased hopefulness and willingness to risk."

### *Discussion*

Neither relational theory addresses the problem of pleasure directly. Different elements of the therapeutic process can be extracted as pivotal to repair and revitalization from each theoretical perspective. We might integrate these theories in the following ways.

Through the lens of self-psychology, if the capacity to experience pleasure is a self-capacity stunted by environmental deficit and/or impingement, we would expect that restoration of the capacity for pleasure to derive from the experiencing of selfobject functions lacking in the early experience of the traumatized child. Theoretically, small empathic breaches followed by repair through vicarious introspection on the part of the therapist and communication of empathic understanding by way of interpretation may provide a regulatory selfobject function that might effectively address problems with the experience of pleasure in some adult survivors of relational trauma.

Through the lens of relational-conflict theory, we would expect that the restoration of pleasure would be embedded in the co-creation of a new relational experience between the clinician and patient. Theoretically, the individual's relational blueprints may be so constricted by traumatic experience that exploratory behavior becomes limited to the repetition of patterns of engagement, which are either retraumatizing or rigidly reenacted.

The therapist's ability to reflect upon these reenactments and offer other relational possibilities may also effectively engage the patient's capacity for pleasure. This research presupposes that some adult survivors of childhood abuse and neglect present with problems of pleasure and that those problems can effectively be addressed in psychotherapy. How? What types of interventions might be experienced as enhancing the patient's construction of a narrative that includes the experience of pleasure? What therapeutic action might revive or revitalize the capacity for pleasure?

If pleasure is part of the patient's authentic subjectivity, experienced through certain patterns of engagement, then developing both the capacity to initiate, to become

an agent in the creation of one's own pleasure and the capacity to respond with pleasure to such overtures from others, may be essential to the person's experience of pleasure.

Many relational theorists argue that enactments engage the possibility of the development of new and more complex ways of being. Though crediting the necessity for a relatively stable sense of sense, these theorists argue that authenticity is constituted and enhanced by the capacity to experience more complex and multifold selves. Might the capacity to experience pleasure be just such an enhancement?

## CHAPTER III

### METHODOLOGY

#### Research Question

This discussion leaves us with many theoretical propositions about pleasure that remain to be explored. The primary question is: What is the role of psychotherapy in restoring or enhancing the capacity for pleasure in adult patients with reported histories of chronic childhood abuse and/or neglect?

Within the exploration of this question many other issues arise, all of which could not be addressed within the scope of this study, but warrant our attention. What interferes with pleasure seeking, developmentally? Why do some people seem to suffer a disruption to their ability to experience pleasure more than others, despite similar histories? Why do some people, in the face of disruptions, tend to funnel their pleasure-seeking behavior into perversions and others turn towards self-injury, while still other more actively turn towards avoidance? If the source of the problem is primarily in developmental/ traumatic disruptions, rather than in problems of endowment, what, therapeutically, enables development of the capacity to experience pleasure to either resume or be restored? How do therapists address, recognize, and/or reflect with their patients upon these dilemmas? Do they? How do therapists avoid recognition of these problems? How do patients experience these problems in their lives? How do patients discuss, reflect upon, or avoid recognition of these problems in the therapeutic process? Do patients who experience problems with pleasure find psychotherapy helpful in addressing these dilemmas? If so, how?

### Initial Definitions of Major Concepts

Various definitions of pleasure have been explored in the literature. Pleasure is a complex concept to define. It is not a discrete emotion, but is associated with various emotions. Tomkins (1963) described nine universal biologically available basic affects based upon facial expression. In this categorical approach, joy is the emotion most closely related to the concept of pleasure. Panksepp (1998, p. 182) urges the need for a scientific definition of pleasure: “[A] general scientific definition of the ineffable concept we call pleasure can start with the supposition that pleasure indicates something biologically *useful*.” Pleasure may be understood neurobiologically as the activation of any of a number of positive affect states individually or simultaneously.

Other literature reviewed defines pleasure variously as the relief of tension (Freud, 1915): “the amount of increase or diminution in the quantity of excitation in a given period of time” (Freud, 1920, p. 8); “the heart of play” (Perry, 2001, p. 25); and a developmental complexity that begins with the social smile and expands within the context of secure affect regulation (Sroufe 1997). Emde (1991, 1999) and Schore (1994) also both associate pleasure with affect regulation.

The idea of pleasure as being a secondary derivative of object seeking originates in the literature with Fairbairn (1944/1952). Excitation paired with exploratory behavior within a safe context is at the roots of Csikszentmihalyi’s (1990) understanding of positive affect. His work is concerned with optimal experience and explores the components of what he found was necessary to this experience.

Flow is Csikszentmihalyi’s word for the optimal experience. He defines flow as the experience in which “concentration is so intense that there is no attention left over to think

about anything irrelevant, or to worry about problems” (Csikszentmihalyi, 1990, p. 71).

While not denying that other forms of positive affect exist, he argues that the best moments are moments where we are stretched to the limits of our capacities by our active and voluntary pursuit of that which compels our interest.

In this study, the theoretical definitions of pleasure were derived from the data. Participants’ narratives were analyzed for their individual subjective definitions of pleasure.

#### *Statement of Assumptions*

- Trauma, particularly chronic childhood abuse and neglect, can interfere with the development of capacities for self-regulation, promote dissociative coping strategies, and induce hypervigilance to the environment and hyperarousal in the expectation of danger.
- Wherein attention to pleasure may become absent or linked to noxious stimuli and sensations, pleasure can become potentially confounded or avoided.
- While therapy has the potential to address these problems, it may not do so.
- Narrative data from interviews with matched pairs of patients/therapists may yield information that will further inform us about definitions of pleasure and treatment process. Whether pleasure is recognized and addressed, this data may inform understandings of whether or not recognition affects the experience of pleasure.
- Narrative methodology as outlined by Riessman (1993, 1994) provides a systematic approach to analyzing narrative data.

- Both the structure and content of the narrative will lead to information about how patients make meaning of pleasure or the lack thereof, and the impact of psychotherapy on this process.
- The results of the narrative analysis will then be examined in the context of the literature review to determine areas of agreement, disagreement, and potential advances in theory.

## Research Strategy and Design

### *Scope of Study*

There has been little discussion of impairment of the capacity to experience pleasure in the study of adult survivors of chronic child abuse and neglect. No studies were found that examine the impact of the therapeutic relationship on either enhancing or restoring the capacity for pleasure in these patients. This study examined how this patient population and their therapists defined pleasure. The similarities and differences in patients' descriptions of what was and was not useful in the therapeutic process in enhancing and/or restoring capacities for pleasure were compared to the descriptions given by their therapists.

The problem of pleasure is central to the life dilemmas of children and adults who have survived child abuse and neglect. This population is enormous. The U.S. Department of Health and Human Services and National Center on Child Abuse and Neglect investigated allegations of an estimated 3,598,000 reports of six million maltreated children in 2005 (U.S. Department of Health and Human Services, 2005).

In 2005, 1,490 children died, while an estimated 899,000 children were found to be victims of abuse or neglect; 80% of these children were injured by their own parents (U.S. Department of Health and Human Services, 2005). Children and adult survivors present a variety of symptomatology, which includes depression (Browne & Finkelhor, 1986; Polusny & Follette, 1995), anxiety disorders (Mancini et al., 1995), self-mutilation and suicidal behavior (Green, 1978; van der Kolk, Perry, & Herman, 1991), sexualized behavior in children (Cosentino et al., 1995), sexual dysfunction in adults (Russell, 1986), substance abuse (Dembo et al., 1987, 1990), complex post-traumatic stress disorder (Herman, 1992), and dissociative disorders (Saxe et al., 1993, Putnam, 1997).

Putnam states, “[M]ost studies find that the majority of traumatized children manifest one or more symptoms that fall within the core PTSD symptom set” (1997, p. 32). Additionally, the DSM-IV-TR (2000) contains a long list of features commonly associated with PTSD: numbing, persistent arousal and re-experiencing, phobic avoidance impaired affect modulation, somatic complaints, social distress, compromised relationship functioning, shame, despair, and hopelessness. All the aforementioned clinical problems may involve a loss of both psychological and physiological equilibrium, which induces the avoidance of, disruption of, or inability to experience pleasure. The questions of how pleasure was developmentally disrupted in the context of trauma, how individuals experienced this disruption in their adult lives, and how these problems were addressed in their psychotherapy will be explored.

## Data Management and Analysis

### *Setting, Population, and Sampling Sources and Nature of Data*

Availability sampling was used to recruit participants for this study (Rubin & Babbie, 2005). Participants for this study were recruited from two populations. The first population studied was therapists of adult survivors of childhood abuse and neglect. The second group of participants was recruited from adult survivors of childhood abuse and neglect who were currently engaged in treatment lasting over one year or those who had completed treatment.

Subjects were recruited through e-mails sent to members of professional organizations, professional workshop handouts, postings at psychology and social work conferences, as well as flyers posted in clinical and medical waiting rooms. Most of the therapists recruited their patients and some of the patients recruited their therapists. One short demographic survey was the only additional instrument used (Appendix D).

In this qualitative study, adult patients and their therapists were interviewed about the patient's experience of pleasure and what was thought helpful in the therapy process. Sixteen patients and 15 therapists were interviewed for this study. One patient interview was dropped from the data, as the patient's therapist never completed her interview. Three other patients who applied to the researcher as study subjects were dissuaded from participation upon initial contact. It did not appear that these subjects adequately felt that they were entitled to the right of refusal.

Subjects were interviewed individually for approximately 90 minutes. Riessman's (1993, 1994, 2008) narrative analysis methodology was used as a beginning guide to ask open-ended questions intended to elicit how the patients and their therapists understood

and made meaning of pleasure within the context of their life and their experience in therapy.

Patients were interviewed about their definitions of pleasure, their life experience of pleasure, and changes in that experience during and after psychotherapy. They were asked to describe their experience of pleasure. Therapists were interviewed about their experience of the therapy with their patients and asked open-ended questions to help them articulate what they understood about their patients' life experience of pleasure and ways that this was addressed in the course of therapy.

Subjects were also asked about the exploration of experiences of pleasure within the psychotherapeutic process. Both members of the clinical pairs were asked what they felt in the psychotherapy had helped change the patient's experience of pleasure. Questions that were used as an interview guide are denoted in Appendices E and F. All patients were interviewed prior to interviewing their therapists. Every subject was invited to follow up with the researcher should they have additional thoughts after their interview was completed.

Pleasure was not operationally defined. The researcher depended upon the subjects' own perceptions and definitions of their experiences. Differences and similarities in subjects' definitions of pleasure will be discussed in the findings.

Interviews were assessed to give voice to the significant factors, as described by the patient-subjects that had defined their experience of pleasure and their difficulties with pleasure, both historically and as addressed in the therapeutic process using Riessman's (1993, 1994, 2008) methodology as a beginning guide. Themes that emerged

for each individual, for the patient group, and the therapist group are delineated (Riessman, 1993, 1994; McLeod, 2001; Creswell, 1998).

How narratives were constructed to create meaning is analyzed. As narratives were reviewed, attention was given to assessing similarities and differences within the narratives of therapeutic pairs regarding the subject of pleasure within the therapy process itself. Additionally, interviews were reviewed to evaluate similarities and differences between the themes that emerged from the patient group, as contrasted to those themes that emerged from the group of clinicians (Dalenberg, 2000; White, 2004). Results are compared to previous theories presented in the literature review about definitions of pleasure. Of the literature review, only one qualitative study (Csikszentmihalyi, 1990) was found in which subjects were interviewed about their experience of positive affects. Though subjects in this study were known to be adult survivors of abuse and/or neglect, they were asked about their experiences of pleasure. The results of this study are compared against the results of Csikszentmihalyi (1990) for definitions of pleasure.

### *Data Management*

All subjects signed an informed release (See Appendix A). All subjects' identities are protected and confidential. Interview subjects were assigned a letter and a number for transcription purposes. All patient interviews were coded as "A." All therapist interviews were coded as "B." Clinical pairs were coded with the same number. The sample was thus coded as 1A and 1B through 15A and 15B. All identifying information has been removed from the transcribed interview and interviews were coded for identities so that

subject identities can and will be kept separate from the data. All transcriptions are kept in a locked fireproof box.

#### *Statement on Protecting Human Subjects*

These subjects are considered part of a population that is potentially at risk. Asking questions about both their trauma histories and psychotherapy could potentially be upsetting. However, several studies of adult trauma survivors have shown distress to be minimal (Carlson et al. 2003; Barlow, 2007). Carlson et al. (2003, p. 138) found in an inpatient population of subjects that “70% of participants whose level of upset was known experienced low or moderate levels of distress when answering detailed interview questions about PTSD and trauma and about half (51%) found participation to be at least somewhat useful.”

Subjects in this study were outpatients who would be presumed to be less psychologically distressed than an inpatient population. Risk was further mediated by the availability of patients’ therapists and instructions to therapists to only invite those patients to participate in this study who they think will benefit.

#### *Limitations of the Study*

This was an exploratory study of a very small sample and hence not generalizable to any larger population. With only one interviewer, results were completely left to the sole interpretation of the researcher. Comparisons are made to data from other interviewers conducting similar research, which were few. Implications of this data are thus limited.

This study is limited by a self-selected sample. These findings may be an artifact of this sample. Subjects may have volunteered for the study due to innate capacities that rendered the topic more salient for them. Subjects' preexisting interest in the subject of pleasure may be indicators of capacities and bias that cannot be separated out from the data.

### *Implications for Future Research*

There is a paucity of psychodynamic research about pleasure. We need to further investigate the post-traumatic disruption by survivors of childhood abuse of their own pleasure. Studies are needed to investigate the many consequences of internalization.

Future research is also needed to address the following questions.

- Would these subjects' definitions of pleasure hold up in a larger sample?
- What are the variety of ways traumatic experience is re-enacted.
- Questions arise about what the meaning in the therapeutic milieu of the therapist's pleasure or lack of pleasure is in her relationship with the patient?
- How do patients' understand what is helpful or not in psychotherapy?
- Is pleasure a resilient capacity?
- Can pleasure be understood as a subset of one of Tomkins innate affects of interest/excitement or joy/enjoyment?
- How do we study the development of self during a psychotherapy?
- Is pleasure a factor in the elaboration of self?
- Can individual capacities be separated out from some overall organizing structure of mind?

## CHAPTER IV

### INTRODUCTION TO THE STUDY

#### Findings and Definitions of Pleasure

The next five chapters represent the findings of this study. Each chapter organizes some thematic understanding derived from interviews with both patient-subjects and therapist-subjects. Chapter V is entitled “The Disrupted Story.” This chapter introduces the findings in general and discusses the variety of ways that patient-subjects articulate the disruption of pleasure in their lives. First discussed is how therapists and patients defined pleasure. The discussion that follows illuminates the variety of external interruptions and assaults upon pleasure that this population experienced. The chapter ends with a discussion of the internalized patterns of disruption that the subjects expressed.

The second chapter of the findings, “The Crossover,” compares the narratives of the patient-subjects with those of their therapists. Upon review of the transcripts, a remarkable congruence was found between the stories told by therapists and patients. How the stories were told differed, yet in a relatively brief interview of approximately one and one half hours, in response to the most minimal of prompts, therapists and patients consistently told the same story.

The third chapter of findings, “Out of Frame,” discusses moments of import wherein the therapist-subjects stepped out of their usual therapeutic frame. There is a

long tradition in the field stressing the importance of maintaining an ethical and therapeutic treatment frame. The therapist-subjects in this study all clearly spoke to their beliefs in the necessity of a clear treatment frame.

Although all the therapists are psychodynamic practitioners, they varied in the particulars of how they constructed that frame. Of note in the data was the number of therapists who commented on a particularly significant therapeutic moment of engagement outside their normative treatment frame. For every therapist-subject who told an out-of-frame narrative, their patient told their own version of this *same* moment. The same moments that surprised the therapists were experienced by their patients as pivotal to the success of the therapy.

The fourth chapter of findings, “Repair: Everything is Possible,” discusses the relative importance of pleasure in therapeutic repair. So is pleasure important in the therapeutic paradigm of repair for survivors of chronic childhood abuse and neglect? In this study, all subjects endorsed both the idea that the capacity for pleasure was essential to healing and that pleasure itself was problematic. In this chapter, we will discuss the importance of pleasure to these subjects, review how pleasure is problematic, and then discuss what they found therapeutically helpful in repairing their difficulties with pleasure. Their therapists’ perspectives on what was helpful will be compared.

In the final chapter of the findings, “Finding a Self,” we will discuss the surprising determination of the subjects to educate the researcher. This chapter enumerates the various steps along the way to finding a self. Discussing pleasure for these subjects was so intricately interwoven with the fabric of identity that the importance to them of finding a self emerged over and over again in the interviews. It is interesting to

note that the researcher made no conscious attempt to facilitate a conversation about the development of self across the life of these therapies. Subjects were never asked if they experienced a change in their identity over time. Subjects spontaneously spoke about finding a self in the context of talking about pleasure and the problems they had experiencing pleasure. Upon doing a word search, the researcher was astonished to find in the interview transcripts that subjects had used the word “self” approximately 400 times.

### Introduction to the Study

This chapter discusses the variety of ways that psychotherapy patients who were subjects in this study articulated a narrative describing the disruption of pleasure in their lives. The story of this disruption is told both by the patients themselves and by their therapists. First discussed is how therapists and patients defined pleasure. The discussion that follows illuminates the variety of external interruptions and assaults upon pleasure that this population experienced. The chapter ends with a discussion of the internalized patterns of disruption that the subjects elaborated upon.

Sixteen patients and fifteen therapists were interviewed for this study. The sixteenth patient interview was dropped from the data, as the patient’s therapist never completed her interview. Three other patients who applied to the researcher as study subjects were dissuaded from participation upon initial contact. It did not appear that these subjects adequately felt that they were entitled to the right of refusal.

All of these interviews were predicated upon borrowed trust. The patient-subjects decided to participate in the study after consultation with their therapists. Most of the therapists recruited their patients and some of the patients recruited their therapists.

All of the patient-subjects said they were concerned about their safety in relationships. Feeling safe with me was a criterion for their decisions to participate. They felt safe because their therapists told them that I was trustworthy. My long experience in the field working with survivors of abuse and neglect was important. They said I would understand “people like me.”

My being female was also a factor. One subject laughingly said, “You know I’m here because my therapist says you’re all right. But you understand that if you were a man, I would never have shown up.” He was abused by men, as were most of the subjects in this study, and told me that he was still trying to “work out that there were good men in the world.”

Most of the patient-subjects spontaneously said they felt empowered by the opportunity to participate in the study. They hoped that they would be able to help. They wanted to contribute something, give something back for what they felt their therapists had given them.

They wondered if their stories would help therapists help someone else. Even so, these subjects struggled with pleasure. Their pleasure in participating in the study was not without conflict:

I don’t have a lot of pleasure in my life unless it’s something that I feel, as if it’s serving a purpose for someone else or, you know, I think to a certain extent it is, uh, somewhat of a pleasure, but not just pure joy. I mean, it is a pleasure for me to, like, even coming here today, um, there was some struggle with that because initially I was, I wanted to, to do it because I would be helping you to help others.

And then there was some sort of, a little bit of excitement about just the process of it.

### Definitions of Pleasure

How did these subjects define pleasure? Pleasure was experientially defined by the subjects. The patient-subjects made a clear distinction between definitions of pleasure and activities that were harmful, but which provided distraction from pain. Coping and escapism were not retrospectively seen as inherently pleasurable. Subject 5A was particularly articulate on this point:

Before therapy, I would say pleasure was really discombobulated. I mean, it was just all based around drugs and sex, um, you know, sick relationships. I really didn't do anything for myself at all or have a lot of self-interests, and, you know, I would say, you know, lot of drug use. A lot of drinking, and I felt that that was pleasurable at the time. I don't think I realized what real pleasure was, you know, and sometimes, today, I really have to think back, is this something I'm enjoying, is it something pleasurable to it, especially without the drugs and alcohol and without being in a sick relationship or something like that. I've had to really find things.

She goes on to say she learned to cope as a child "by escaping from reality. This was through my imagination and daydreaming most of the time. Later, as an adult, the forms of escapism that I came to know came through alcohol and drug use or making believe something was real that wasn't." Subject 6A describes the problem this way:

I used to listen to a lot of angry music [deep breath] which fueled the rage and I used to think that was pretty pleasurable, because I could actually feel the adrenaline pumping through my veins. I don't know now; it's scary. I don't listen to that stuff no more. I kind of fell back into it, but I told, told her [his therapist] her about it and so I returned the music back to the library.

Definitions of pleasure were both complex and multi-faceted. Two major categories were delineated. Pleasure that derived from the idiosyncratic organization of

the self, sensory pleasure, and interests were often discussed. Pleasure in and with others in relationship was an even more predominant theme.

*Pleasure in the Freedom to Pursue One's Own Interests:  
Agency, Identity, and Initiative*

In this category, subjects talked about things they liked to do, the pleasure of being free to pursue that which interested them. Examples of these pleasures are not without conflict. Subject 4A discusses how she learned to knit:

I actually I learned it years ago; I do some pet care and a client was a knitter and I noticed that then and asked if she would teach me and it seemed something, at the time, that it made her happy. I could see, too, that teaching me and having me interested, you know, we did a barter; it helped, too, 'cause she taught me knitting as payment for my care of her animals. I thought it would be good because I, like, have picking and chewing issues with my fingers. So, it was sort of like a purposeful thing to do, was the initial thing. And I also have trouble also accepting money for anything that I do; I have issues with that, as well, so it helped in that regard.

And so I, she taught me and then I was doing it for a while, it was years ago, and then, and then I started to just derive pleasure from the actual knitting itself. And I'm not saying that I was conscious at the time, but I know that I was enjoying it and just unto itself, separation from anything and not just as a means of preventing me from chewing on my fingers.

Pets were mentioned by a half dozen of the subjects as sources of pleasure.

Subject 3A says:

Blake and Jake are cats. They're about three. And, uh, Blake gets into absolutely everything; if there is something to knock over or a cover to get into, he's in there. And so they play a lot and they're, and they're really silly, so, they make me laugh. I have parakeets. They're very, very messy. [Laughs] But, I have parakeets 'cause I like the sound of the, the chirping in the house. Seven. I've got a really big cage for them. So they all live together. Yeah. And then I've got a couple aquariums. I've always had, love fish and all kinds of animals. I would adopt many more if I could. I want to adopt another dog, but Mickey would just pack her bags and not be very happy.

Another subject vividly described her joy of water. Subject 5A says:

I find a lot of pleasure in water. If it's a pool, if it's an ocean, I'm really just, there. I find a lot of, that's where I feel freest, is when I'm in the water. Like, you know, and getting under it with nobody, just my thoughts, nobody can hear me and I can make noises and only hear them myself. And so, I, I love the water. I love the waves. I'm not a great swimmer, but I can just stand by the shore and let it knock me down for hours.

I feel just beautiful. That's where I feel my most sense of peace is by the water. And if it's, you know, we got like a little [Laughs] one of those little blow up pools that we put up every year now in the yard and, you know, I just sit in my little lawn chair with my windchimes and I sit in a little floaty chair and I'm happy; I'm okay. [Laughs] Nothing can bother me, so that's one of my great pleasures.

For subject 13A, the pleasure was being on, not in, the water:

For 20 plus years I lived by water; for me, it was boating and probably like 5 or 6 years into being married my husband finally got to the point where I was allowed to take the boat out by myself and that was really pleasurable out in the middle of the water with nothing around you and just feel peace and calm and—and then there's the opposite extreme. We rode motorcycles together, too. [Laughs]

Music was mentioned a number of times as a source of pleasure. Subject

7A says:

I can remember one Christmas we'd gotten a little organ. That was exciting. We could play it, but we couldn't play it very often, 'cause it was irritating to people. [Laughs] You know, we held on to that thing for years and years. I don't even know what happened to it. It was enjoyable to play 'cause I don't remember music ever being played in the house unless they were drinking. And I think there was a lot of times that we could sit at that piano or organ, which is, it was right at the window, and we could watch out, 'cause we didn't get to go outside a lot, but we could watch outside and just, trying to play, to read the notes, and make something sound good.

Numerous pleasurable activities were delineated by subjects. In addition to those already cited, subjects told stories of tea parties and baseball games, cooking and painting, doing puzzles and enjoying the fresh air. Many subjects mentioned the pleasures

of reading and writing. Even so, pleasure with and in the other in a relationship was a more predominant theme.

*Safety in Relationship: Pleasure With and In the Other*

Over and over again, patient-subjects talked about safety, both as a pleasure in itself and linked to the possibilities of interpersonal pleasure. “I was safe,” said subject 1A. Talking about the pleasure she finds in her relationship with her dog, subject 3A says, “She’s absolutely beautiful, everybody that sees her says how pretty she is and she’s very protective of me, which makes me feel safe.” Subject 6A smiles as he talks about the comfort of being with his therapist in her office. “I’m not ready to leave the nest yet. You know, I’m not. I cry almost all the time when I have to leave there, I feel so safe there, so connected, it’s like my home away from home.”

Pleasure in connection was a common theme. Patient-subjects talked about their therapists’ reliability and consistency. They were delighted in their abilities to assert themselves, feel protected, cared about, and secure in their therapists’ abilities to maintain appropriate boundaries. Subject 5A laughs as she tells me:

Well, I think by setting really good boundaries with me and I think that’s how I learned what a boundary was, by just realizing that boundaries were there and that they could be set. And that they were good things, that they weren’t necessarily somebody pushing me away and saying, I don’t want you, I don’t love you. That there’s a way to set a boundary in a loving way and, I mean there were times where there was some transference or I’d be pissed off because sometimes I go, I think I have the right to be friends with you, you know. [Laughs] We should be able to hang out together and she just clearly still sets the boundary. You know, she’s like, look, you’re never coming over for Thanksgiving dinner! But we laugh about it.

Subject 10A tells me that “one of the most valuable things I learned in therapy, especially working with C., is she was very consistent. That was what made happy, made me very happy.” Subject 1A makes the same point:

You know, I guess there’s just some people in life that you feel are genuine that you really want to, that want to have, and are consistent. That was a hard thing for me before [Laughs] with the other therapists. Well, she used to cancel a lot, [Laughs] even while I was on my way driving there. And, M. seems like she always remembers what we were talking about and sometimes that other therapist, you know, before, she wouldn’t remember. [Laughs] I’m always so amazed that M. does remember stuff that I was telling her. Yeah, she’s consistent. I think I was always, I didn’t know, I used to be anxious just about going that day to my old therapist, because I didn’t know if she was going to cancel. You know, it just reminded me of [Laughs] a long time ago.

Subjects discussed their pleasure in relationship not only with their therapists, but with others whom they felt a sense of connection and belonging. Subject 15A lights up as she gives this description of finding people in whose company she found pleasure:

I was a good student and in the drama club and all that stuff and I acted and continued on with that in college to even after college. You know, that is one place where I’ve always, kind of, felt like I belonged, because theatre people, in general, are a bunch of misfits that all come together. And it’s just a different group of people and, um, for whatever reason I really fell in love with, with the whole thing and so even, starting in high school, I did a lot of acting and then when I was on my own and, you know, got into my apartment, I was working, I joined a theatre group.

And, I have to say, there I was happy, there, when I was there, in that building doing whatever it was, even though it was exhausting to work all day and then go do that all night. It didn’t seem to matter because I enjoyed myself so much. I went into set design and learned how to do all of that and, it was just a place where I, it seemed like there were no limits to what you could do. I was real close in high school with a bunch, the people in high school, in the drama club and I guess you could say I dated one [Laughs] who is now my best friend in the world.

Next in this extensive narrative Subject 13A talked about her daughter. Clearly, the joy in her adult life has been organized around raising this child. She delights in giving and sharing with her daughter the childhood that she herself never had. She says:

I think my daughter is my biggest pleasure maybe until she turned 13, which was just recently. [Laughs] So I'm still adjusting to her being 13, getting to experience childhood through her, through her eyes. And, maybe I've gone to an extreme because she doesn't want for much and thinks that life is a pleasure cruise. [Laughs] But it's been fun. It's been fun watching her learn and grow and really to see what childhood was supposed to be like. Well, pre-13. [Laughs] I mean, I don't know, people talk about the terrible twos. The twos were wonderful; I loved 'em. The temper tantrums were cute, watching her explore and get into trouble. It was like, wow, she's discovering life. I was fascinated with the twos. It's 13—she woke up and she's 13 and it's like, where'd the pleasure go? You know, literally, she got up, I said, 'Good morning, sweetheart,' and she said 'grrrr.' Okay, she's 13. But I still try; like yesterday we went and saw *Where the Wild Things Are* and I know you're not supposed to do it and most moms would have, we had a little popcorn fight. Was that the end of the world? I don't think so.

For me, it was really fun and it was fun to watch her, knowing that this was something that, whoa, we shouldn't be doing this, but I don't know; I just thought that was hilarious. You know, so it's really, I think watching her learn and grow and to see what happens if and with her quite often I'll take what my childhood was and I'll do 180 degrees. I'll just, okay, that's not happening, but I go to the opposite extreme. But at the same time, it's been so much fun watching what life is supposed to be like for a child. What happens when you give a child the tools they need to grow and see who they become, you know. It's fantastic and it's funny, because she's adopted and everyone that sees her is, like, no way, she looks just like you, you know, it was meant to be. So, I think being her mom is probably the greatest pleasure that I've ever had; I mean, even on the bad days you can find something, you know, pleasurable about it.

Subject 2A tells about the deep sense of connection she always had with her younger brother and now feels with her niece:

My brother is somebody who always brought me pleasure. He's 8 years younger than me. So, he's like my baby. So I've always taken care of him and reading with him is something that I've always loved to do. I do all the voices and the Harry Potter books. We [Laughs] always read them together and so I was starting when he was in second grade. We read them all together until they were done.

But there is always, no doubt, always my brother, my niece. She's 3 years old and she's also like a little world to me. [Laughs] She calls me her fairy godmother 'cause I'm her godmother. They say no, she's your godmother. No, she's my fairy godmother. [Laughs] She's just wonderful; I love her to death."

## CHAPTER V

### THE DISRUPTED STORY

Within the 15 pairs retained for data analysis, a consistent theme of disrupted pleasure emerged, with variations. Every clinical pair told a life story narrative of both the experience of pleasure and the disruption of pleasure. No patient-subjects reported the complete historical absence of pleasure in their lives. All patient-subjects reported some childhood experience of pleasure and some pleasure in their lives now. Pleasure was shown to be a surprisingly resilient capacity in these subjects, despite extremely adverse childhood circumstances of abuse and neglect. Pleasure was preserved and pleasure was disrupted. All patient-subjects reported historical, interpersonal interference with the experience of pleasure. Each reported the emergence of intrapsychic interference with the experience of pleasure across their lifespan.

I've had some great things in my life; I've had some really hard things in my life, but for some reason, I've been able to hang onto those things that really make me happy [Laughs] and get me through a lot of stuff. When I was growing up, it wasn't all bad all the time. You know, so it's not like I want to complain about anything. It's just that, there were some difficult times. [Laughs]

It was hard to get through that. And the reason I even went into therapy is because I just didn't want those problems from my past to bother my present and future. I wanted to be close to people, but I had a problem. [Laughs] I was afraid. So, um, it did effect, not just physically, I mean, you know, trusting someone that much with yourself, you know, to be able to, uh, just be able to breathe around someone and know you can say whatever. And not be afraid. I was always afraid.

This discussion of fear stands in contrast to the previous discussion of safety. While subjects repeatedly mentioned safety as the medium for the experience of pleasure, fear was connected over and over again with the disruption of pleasure. Despite the linking of fear with pleasure in a popular culture of thrills and scary movies, these subjects found fear disruptive.

The repetitive exposure to danger did not create mastery over fear. Fear disrupted their capacities to experience pleasure. Although every patient-subject's narrative included descriptions of their pleasure, every subject also constructed a story of the interpersonal traumatic disruption of pleasure and the intrapsychic repetition of that disruption.

Some told their stories historically, from disruption to resumption of pleasure. Some told of the disruption with only an afterthought of pleasure now. Some told a tale of pleasure with a long reach back into their past with only the afterthought of disruption. However the stories were constructed, they were all stories of problems with pleasure deriving from the interruption of their pleasure through traumatic interpersonal injury.

How Did Subjects Describe the External Disruption of Pleasure in Their Childhoods?

#### *Annihilation of Pleasure*

Subject 10A tells of the disruption of what was precious to him in his childhood. His story describes the malevolent destruction of both a deeply pleasurable relationship and the exploration of his primary intellectual interest. Though he speaks candidly, this story was difficult for him to tell. He was upset as he was describing these events. It is a narrative about his central loss of self. He is still grieving as he tells me this tale. I include

our process, as it was apparent to me that he needed my responses, as verbally minimal as they were, in order to tell this story that he wanted to tell me. He pauses frequently in the telling.

10A: [Sighs] Well [Laughs] pleasure existed in a vacuum. Because I was surrounded by so much horror, I would assume that that, because of the dissociation, earliest memories of pleasure would be living in my own head. I grew up in the country; the nearest neighbor was over a mile away. There were no houses in sight or anything, spending time by myself in the woods. I got a lot of pleasure out of learning. I was studying with a college level student who shared all of his textbooks and everything and I could identify every plant in the forest. That brought an enormous sense of, oh, not only pleasure, but some kind of fulfillment and sense of self and satisfaction. But then it went away. It was also very deliberately stopped.

Janet: Okay, so somebody intervened.

10A: Yeah.

Janet: Interrupted that part of your life.

10A: It's the ability to take anything that gave me pleasure and turn it into something really quite traumatic and horrible. Especially looking back and putting together pieces that are coming back. [Sighs] I guess, specifically it was my stepmother.

[Long Pause]

I haven't really sorted through whatever could possibly have been going through her head; I spend a lot of time trying to psychoanalyze the people around you and then eventually realize you just can't. I am not sure if it gave her satisfaction to do that or if she just felt it was part of her job. I do believe there was some kind of malicious intent and that she enjoyed the suffering of others, so. She was very good at it. The studying in particular.

Janet: Because that was something particularly, that was precious to you.

10A: Yes, and I was [Sighs] I guess I could have been considered precocious. I mean, I was in the sixth grade and studying at a college level.

[Long Pause]

And it was fairly obvious that this was the field that I could have—

[Long Pause]

—really done something with it.

Janet: Mm hmm.

[Patient is agonized telling this story. He needs quiet, patient, empathic attention to continue.]

10A: And, she destroyed it and in the best possible way she turned it into one of the most shameful, humiliating experiences I had growing up. She [Laughs] accused the guy who was helping me of being a sexual predator, because she said there was no way anybody would want to spend time with me like that unless there was something else going on. Derived, possibly, from the fact that that's how her family, possibly herself, responded to me. So, it just brought it to a crashing halt.

### *Pleasure Precluded*

While Subject 10A describes the active intentional destruction of pleasure, subject 4A speaks to pleasure primarily being excluded, not destroyed. The subject describes her mother's control over what pleasure she was allowed or not allowed. Her understanding was that pleasure derived from her own initiative was precluded. My question reflects a lack of understanding. The problem she is describing is not one of constant danger. Her hypervigilance is focused upon her own initiative. Her mother's abuse was not wildly unpredictable. Her mother was reactive to the subject's own sense of agency.

4A: So, I think that that's the main part that has had a problem with allowing me to have any kind of joy, pleasure, it's just too risky.

Janet: It's too risky because you won't be paying attention enough to your environment?

4A: Yeah, not paying attention and also the fact that any kind of pleasure for myself, having a self was the trick, to be if I had a self separate from the abuser, that on any level. I mean, I had to. I kind of mastered really during the time of abuse and trauma, I mastered as much as was possible, what to do to try to avoid, the trauma. And one of the things that triggered it, is just any having a self separate from the abuser. Being and especially having any kind of joy or pleasure separate from that individual. It was presented and it triggered the abuse, so I think that that's played a huge role.

Janet: Do you have one particular memory of pleasure interrupted in that way in your childhood that you could tell me about?

4A: Well, I had a great love of music, but I didn't get to choose what instrument I wanted to play. And at one point I played the cello and the piano and I would record the piano and then play the cello.

Janet: Mm hmm.

4A: I had a little tape recorder and I would play, accompany my own playing, but it wasn't considered within the category of, you know, actual practicing. So, you know, the physical and the verbal abuse would ensue when I would do something like that. That strayed in any way, from what was considered required. It doesn't sound very extreme, obviously, but it's just one little example.

### *Manipulation and Exploitation of Pleasure*

Subject 7A describes how her cooperation was manipulated through the offering of something she desired. The object itself was pleasurable, but not freely given. She lived in poverty as a child. A Barbie doll was an unimaginable luxury.

7A: Because I think there's a hidden agenda most, most likely with pleasure. [Sighs] There's always been something, in order to get the pleasure, there's a payoff for somebody. You know, it never has been given without some kind of attachment to it, behind somebody's thoughts.

Janet: Could you give me an example?

7A: Yeah, I can remember, during some of my really, really horrible abuse with my uncle, in order for him to get me to behave the way he wanted, he was gonna buy me a Barbie doll and I found pleasure in Barbie dolls. But, yet, he turned that around and made it something that wasn't pleasurable anymore. He used the thing-things; he used that to get me to do what he wanted me to do. So, now I question things. Okay, I have pleasure from this, but do I get to keep it? [Laughs] Do I get to own this? Is this mine or is there something that's behind it that's gonna hurt me in the long run? And drinking [Laughs] used to be pleasurable.

Janet: Mm hmm.

7A: Because it was an aid to help me forget and help me relax and help me, you know, play my heart out of my sleeve, so to speak.

Janet: Mm hmm.

A: And now it's, it's not pleasurable anymore.

### *Pleasure is Dangerous*

For subject 14A, pleasure is dangerous. Love is dangerous. Liking sex is dangerous. It all leads back to her father and his exploitation of her vulnerability. She describes the difficulty she has feeling her attachment to her husband. How the attachment itself seems dangerous. Together, as we talk, she is discovering new understandings of how love and sex and pleasure came to be experienced as dangerous.

14A: He was a senior in college, he was a senior in law school. He, he's 8 years older than I am.

Janet: Mm hmm.

14A: Where people used to go, maybe they still do, to meet. And he proposed to me after 2 months and I said, well, I'm in love with someone else. Because I was and that guy had broken up with me because I was crazy and I didn't realize it at the time. But from his point, and also because he had heard about my being raped

by this group of fraternity guys. And, and I didn't remember it. So we got married because he was ready to get married. And it seemed like we would be compatible. And I would say we are compatible. I would not say that I love him because that would be dangerous. I don't; sometimes I think I do and then, but mostly I just try to say, oh it's not such a big deal.

Janet: It would be dangerous—

14A: It would be dangerous. I guess I have the phobia, the intimacy phobia. I do better standing back.

Janet: What I was wondering, when you said that if you have an answer for yourself. I imagine that most people would say that loving someone was a kind of pleasure and you said, we're compatible, but I wouldn't say that I loved him 'cause that would be dangerous.

14A: Yeah.

Janet: And I wonder if it feels that the pleasure feels dangerous?

14A: Yeah, it's probably, at one point when I was older, maybe when I was 16, 15, my parents locked me in the cistern in our house, which was a walled up room. And you had to climb into it. But when that, the window was locked. I was there alone in this basement and my dad came down one night and raped me. And I think that I might have liked it, so, yeah, I think that's very perceptive of you, that it's probably linked to him at that point; everything's linked to him as far as emotions.

#### How Did They Describe Their Own Internal Disruption of Pleasure?

Many subjects described how they now interrupt their own experience of pleasure. Interviews were replete with examples of how these subjects now did to themselves what had been done to them. The interruption of pleasure moves from an interpersonal phenomenon to an intrapsychic event. Subject 4A says:

I disappear with a lot of sleep and I'm constantly censoring myself. I don't go to movies or things like that. I read, but a lot it's hard for me to read, just 'cause it feels like the knitting. Knitting I love, that but I don't ever do it because once it has started to be something that was just purely pleasurable I got. I discuss it with my therapist, like it's a phobia of sorts, because it became something that was just purely for me.

And then it became something that I couldn't do until everything's crossed off my list. And I can never get everything crossed off my list. So, it's a huge thing that I'm working with, working on with my therapist. I am struggling with deriving any pleasure, any, that is purely for me. And so there was that aspect of just, um, that wasn't permitted.

15A describes her own self-sabotage. She unconsciously arranges for herself to feel humiliated at a moment of achievement:

I guess primarily the first thing I think of saying is it takes a lot to feel pleasure, feel, uh, like I'm in the moment and, and especially around happy things and happy gatherings and that kind of thing. Um, you know, I think back to, well, specifically, like, uh, my senior year in, uh, college.

I had won this award where we were told to, to show up to this assembly somewhat dressed up, because there was a possibility you were winning an award. [Laughs] So I was so, at that point, down that dressing up, just, nothing mattered to me, really. And, so I went and I was in jeans and t-shirt. You know, looking like a ratty college kid, I guess. And, I thought I was just gonna go up with a group of people for whatever the honor association was at that point, but I didn't know that I was going to win an award. It was the first time it was being awarded for people who made a contribution to the community and service oriented and that kind of thing, and it was a cash award. But they made sure they brought it up at this thing so that caused me to have to go up there all by myself.

And what should have been this, kind of, really wonderful, overwhelming thing. I found myself in, feeling two ways: Embarrassed at the way I looked and, um, I just wasn't as happy as everyone else seemed about. And I didn't exactly know why, then; I mean, I can look back now and see but, you know, I always downplayed anything that might have been good about, you know, happy or whatever.

Subject 10A is very clear about his own internalization of the disruption of pleasure. This is a topic that is familiar to him.

10A: I've done a lot of work on it. I think that it became, interesting word, that it became integrated. I think there was absolutely a point, probably before I even left home, that I internalized the interruptions and that it was no longer necessarily outside forces but things from within. There's an enormous sense of guilt to feeling good about anything and fear, a lot of fear.

Janet: Do you feel like you experience pleasure in your life now with less disruption, less guilt, without guilt?

10A: Yes. I do not believe I experience it as intensely. I think it's more consistent, but much more low key, because that seems to be what I can handle without tripping those earlier triggers.

Ultimately, for many of these subjects, manifest displays of pleasure historically disappeared. Preoccupation with the trauma and the secret of the trauma predominated. This subject describes both the initial frantic attempts to keep awareness at bay and the development of a lifelong coping mechanism that virtually excluded the possibility of a relaxed enough state in which to experience pleasure. She says:

Pleasure, kinda, got lost. Issues started to happen; I started being very scared. I started to be afraid to be in the house by myself. I started to, needed to, go and see a psychiatrist who wasn't very helpful, who was medicating but still it didn't bring anything, no happiness was brought back by the medicines.

I don't know; sometimes, when you get hurt and you don't want anybody to know, actually you can't get any help. So, we think it's a secret, everything is, you're not feeling well. You're not doing well but you pretend like you don't know why you're not doing well. Everybody else is trying to guess why it is. And then you start blocking things, you start to come up with reasons. Well, I'm afraid of the thunderstorms and that's what's causing this.

And that just, I don't know, things don't get better. They just get put back, back, back, back there, just push it back and don't think about it, just move on, you have to move on. And you're moving on but something you lost, you got moved, definitely you moved to the next step, to the next class, to the next year in school, to the next year in life, but things get, kind of, lost and I am not finding it.

You don't even want to find anything; you're not getting help because you don't want help, you just want to get busy and get going and just try to forget the stuff and leave it, leave it and just move on. And after a while everything's back

really sad. And now everything for me regarding happiness is short life, short-lived, you're talking seconds, you're talking minutes, uh, doesn't last very long.

Anything, I can't seem to keep it. What's pleasure, I don't know, exactly, how to define, what, what's pleasure at this moment might not be pleasure tomorrow. Like I said, it's very short-lived for me and I'm happy about something for a few seconds and I'm happy about my daughter being able to do something, to achieve something, to do something, but it might be, just, let's say, 50 minutes, an hour, and then it's gone and it's just, then, to move on, move on, get busy, keep busy, keep busy, keep busy, just go, go, go, go, go, go, go, go.

Don't, don't analyze too much on anything, just go, go, go to the next thing because, I think, analyzing it more, maybe, brings more negative things to look at and more then it will get harder and harder to actually find any happy moments.

### *Salvaged Sequestered Pleasure*

What is striking in these patient-subjects is that, overwhelmingly, pleasure did not disappear entirely. The disruption of pleasure was internalized and reported as an ongoing problem in their adult lives, even when they were no longer living with or physically dependent upon the people who had originally injured them. They still reported experiencing pleasure. Pleasure continued to be an aspect of their lives, however compromised. Pleasure was often salvaged in private moments and opportunities to be in the presence of those who did not injure them.

Several subjects said that they had grandmothers who sometimes offered them a reprieve. Subject 1A says:

Umm, almost anytime, spending with my grandmother [Laughs] was good. I mean, I used to spend as much time as I could with her. She had a fishing resort. I would go up there and spend my weekends and summers [Laughs].

Sometimes after the diner would close and we would go sit just by the water and she would [Laughs] probably she didn't even feel like doing it, but she did it with me, and she would just sit, and just dangle her feet in the water with

me. And [Laughs] just to spend time, it was great. Almost anytime spending with my grandmother [Laughs] was good.

The following sequence happened about halfway through an interview with a subject who, up until this moment, had told me a great deal about the horror of her childhood, insisting that she had always been miserable. I inquired further to see if I accurately understood what she had told me up to that time. In response, she then told me this story about her grandmother.

Janet: What you're saying implies, so I want to make sure I know, that you have no memories from childhood of anything pleasurable, is that true?

A: Okay, let me think. I had one grandmother who lived downstate, my mother's mother, and she would take me places and I would see her, maybe, once a year and she was nice to me and she's probably the one person in my life that has allowed me to love anything.

Janet: Could you tell me any pleasurable memory about being with her in particular?

A: Uh, yeah, well, this isn't really, it's more what. Yeah, she took me to Wakefield in her old clunky car.

Janet: Mm hmm.

A: About 1950-something, and she took me to Sears and I had 5 dollars and they had an escalator and she let me buy what I wanted and then she took me out. That was nice.

Janet: Mm hmm. Could you say a little bit more about what was nice about it for you?

A: Well, she just spent some time with me, there was no pressure. My dad wasn't there. My mom wasn't there. And she didn't have to do it, but she did. So, I think that's why I spent so much time in Crawford, so much of my stuff is location bound, that she lived south of Crawford and I would go down, and when I was working. I had to go to Crawford about every other week and some nights I would get in the car and I would drive down to where she was, stand around down there.

Janet: It sounds like you're talking about even after she died.

A: Oh, yeah. Yeah. [Blows her nose] A lot after she died. She died when I was in college.

Janet: So, you drove to Crawford and the feeling about going to Crawford was?

A: Oh, I think I was happy.

While Subject 14A seemed startled by the depth of feeling she had for her grandmother, Subject 5A could hardly contain her excitement talking about this woman she loved. She says:

We lived across the street, my grandmother lived across the street from a park and, a forest park, and they had this great big pool. And, in the summer before the pool opened they had, like, these little table hockey games and chess games out and so I'd go there about an hour early. She'd take me to the park and she was just beautiful. She would sit there for God knows how many hours, and I'd learn to play chess and I'd play these little hockey games and then she'd let me go in the pool and she'd sit and sit and watch me for a little while and, then she'd go back home, walk across the street, and start dinner and I would swim and swim and swim and she'd come and get me and I'd look up and there she'd be, sitting on the bench with her rosary, and she'd look at me and tell me, come on, time to go. And I'd get dressed and we'd go home and eat and I'd sit by her.

Lots of times she'd pull a little stool up next to the stove and she taught me how to, you know, I learned, I'm the only one in my family now who can cook, because I watched her, you know, I mean, I watched her and she was, oh, she was, as about as tall as I am, but she was this really round woman [Laughs]. She probably weighed, I don't know, 400 pounds and she had these great big fat pillow arms and these really huge breasts and, oh, she had this big chair and I would sit on the arm of the chair and she'd just scoop me up and I'd lay there and just fall asleep on her all the time, on those big fat pillow arms and on those big breasts and, and, just, you know, the sun rose and set in me with her.

Others who did not mention people who sustained them did frequently mention the private activities that they could engage in alone. Pleasure was to be had in reading and writing, biking and hiking, music and pets, studying and drawing. Here, Subject 11A

talks about not only her discovery that she could draw, but the realization that her pleasure in this ability salvaged her self-worth. She says:

It probably started from when I had rheumatic heart when I was about 3 or 4. And everybody else could run around, the doctors thought I had rheumatic heart and I was, I was told I need to sit down on the porch and so somebody would eventually give me a pencil and a piece of paper [Laughs] and I'd start by drawing little birds and things.

And I think so that I wouldn't feel bad people would say, oh that's nice, or, I like it. And, so it, it, it just became something that I could do in lieu of running up and down the street with the other kids. That I did it myself. [Laughs] It was almost like my something from nothing. It was something that I could do. And it's probably actually one of the first, and probably for a long time, the only thing that made me feel like there was something special about me.

Whatever we understand about the function of pleasure, this population exhibited a remarkable capacity to derive some pleasure from terribly difficult circumstances and to continue to protect some portion of pleasure within traumatically compromised lives. The resiliency of their capacities to experience pleasure is worth further study.

As this is a self-selected population of patients who report having excellent therapeutic alliances, we might wonder if their capacity for pleasure is unique among survivors of severe, chronic childhood abuse and neglect. Does a resilient capacity for pleasure make it more likely that survivors will seek therapy? Are they more likely to have a successful therapeutic engagement? Or does a successful therapy rekindle the capacity for pleasure and foster a retrospective narrative that includes pleasure as a part of one's past experience?

## CHAPTER VI

### THE CROSSOVER

Every clinical pair of subjects told thematically the same narrative. All the patient-subjects were interviewed first. Interviews with their therapists were scheduled after the patients had spoken to the researcher. The researcher purposely chose to hear the patients' stories first. When interviewing therapists, the researcher had no difficulty recognizing their patients.

Upon review of the transcripts, a remarkable congruence was found between the stories told by therapists and patients. How the stories were told differed, yet in a relatively brief interview of approximately one and one half hours, in response to the most minimal of prompts, therapists and patients consistently told much the same story.

Patient-subjects were asked to speak about the experience of pleasure in their lives. They were encouraged to begin wherever they wanted to in their life narrative. Some subjects began with their history and worked their way to now. Others began with now and worked their way backwards. Others wandered back and forth across their life experience. All were eventually asked if and how therapy had affected their experience of pleasure.

### The Therapist's Pleasure

Therapists were asked to reflect upon their patients' life experience of pleasure. They, too, organized their stories along a variety of time sequences. They also responded to the request to reflect upon the impact of the therapy on their patients' experience of pleasure. Therapists were *never* asked to reflect upon their own experience of pleasure. Yet the researcher was surprised by how frequently therapists spoke about their own pleasure in the relationship with their patients.

Subject 2B comments in the following way. She began the interview by telling me that she wanted me to understand her pleasure.

Well, I'll start by saying that I think this is a huge subject [Laughs] and that I don't generally think about pleasure as I'm thinking about, well, is that true. I know this is about my patient's pleasure. On the other hand, it is not irrelevant that I experience pleasure anticipating her coming.

The therapists sometimes had so much to say about their own pleasure that the researcher felt compelled to assertively redirect the conversation back to the patient's experience of pleasure, as illustrated in the following example. The therapist-subject opens the interview by speaking to her own pleasure. She says, "Okay, um, thinking about pleasure with my client. Um, I think in, I'm thinking about when we sit together, it's often pleasurable just being in each other's company." Ten minutes into the interview, she is still speaking about her own pleasure. Finally, we have the following transaction. The therapist at first seems puzzled by my question. There are long pauses before she begins to speak about her patient's pleasure.

Janet: Okay. I was wondering if you could talk some about what's pleasurable about the connection over a range of emotions for him; what do you think is pleasurable about that?

6B: Mm.

Janet: For him, and if you have any examples in mind?

6B: Sure.

Janet: Examples of that?

6B: Okay. Yeah, let me think; I'm, what's pleasurable for him is, and I'm thinking with the range of emotions that we're able to feel together, that that's, um, I think that feels like a model for him. That, that that's okay, that that's something that is acceptable. I think there's an acceptance going on there. That this is, sort of, what relationships look like and, I think, that, for him, feels good because that wasn't given to him as a child and we've talked about that, you know, models for communication or laughter and sadness together.

Although many other therapist-subjects also spoke of their pleasure in their patients, Patient-Subject 6A also spoke about his therapist's pleasure in their relationship. Here he contrasts his relationship to other therapists with his relationship to his current therapist.

6A: [Deep breath] I get in touch with who I really am. Figuring out what I like, what my hopes are, my dreams.

Janet: How come you think you've been able to do that with L.? I think you said you had some other therapists who didn't work so well, right?

6A: Nah, because L. actually listens, but she also gives me her input. And she's compassionate and I can see that. I didn't have a lot of that growing up. No one actually took the time out to listen and gave time for me, you know, 'cause when I go there that's, that's my time, and that's what, that's for me. She helps me feel that, like that. She likes me. I don't know if what I'm saying is making sense.

Janet: Well, it does, and I, what I'm wondering about is that you saw—

6A: [Deep Breath]

Janet: —other therapists who made some time for you, right, but it wasn't the same.

6A: No, it wasn't the same at all because—

[Long Pause]

Janet: So, yeah, why?

6A: Uh, because seemed like they were just doing a job.

Janet: Mm hmm.

[He pauses again for a long time.]

6A: There was no real feeling going, no real, humanizing or no sense of—I'm all about emotions and all about being human, humans are emotional, and I didn't sense that with those therapists, not at all. Which is odd, because they were women, too, all my therapists have always been women, but I didn't feel like that with them, they've just felt like, they were just there to do a job. And, and I didn't connect with them.

Janet: Mm hmm.

[Again, he pauses for a long time.]

6A: 'Cause I wasn't able to talk about what I really needed to talk about 'cause I didn't feel it there. [Deep Breath] I just didn't feel it. They didn't really give me any feedback on anything or they didn't really listen that much or I didn't feel like they actually listened to my feelings or really care about me getting better. I hope I'm making sense.

Janet: You are making sense.

6A: Um, I just didn't feel it and I, as soon as I walked into see my therapist now, L., every time she lights up when she sees me. When I first walked into, to see L., it was just like, I knew. 'Cause, I don't know, I just got that vibe [Deep Breath] just by the way she, I don't know, I talked a lot about her today didn't I? I mean, 'cause I, I connected with her. It was just like, I just knew I was at the right place at the right time and the right moment.

His therapist also describes their relationship in similar terms. In listening to this clinical pair, the researcher could consistently feel how much these two people liked each other. The therapist says:

There's other times where it's lighter, maybe connecting over humor, because he's just funny, you know he's witty and clever and has a great laugh and smile. I get his sense of humor and he gets mine, so we connect in that way [Laughs]—in that, sort of, fun. You know, that feels fun and enjoyable that we have the range of emotions that we can feel together. That also feels good to me. That, he can cry and I've cried with him and then we can laugh [Laughs] together, too and so, I think it's just having that connection around the range of different kinds of emotion. And then, you know, we talk about how that happens in relationship and that's normal in relationship.

#### The Therapist's Commitment

Clinical pairs told the same stories about a multitude of topics beyond their pleasure in each other's company. The following clinical pair both mentioned the importance of the therapist's commitment, as exemplified by her attendance at monthly trainings in the treatment of dissociative disorders. The patient, Subject 3A, in speaking about her therapist says:

She's very compassionate and validating. One time before we start seeing her, our previous therapist, somebody that was supposed to be an expert, and she was cold, her office was cold. She looked like she was just doing a job, not really caring. My therapist now, you could tell she really cares and it means the world to us that she's working with the ISSTD. The fact that she's doing that, it helps us really know that she is really committed to getting the training she needs to help us. When we pray every day, thank God for her and her commitment and the fact that she's working hard to do it right and not make us worse.

Here, her therapist, 6B, speaks to the same point. She says:

She'll say something sweetly regressive, like, you're my Dr. W. And she lists a couple of things in recent memory when I was worried about her. That she can recall those now. That's what I was thinking we have discussed, when she felt

okay. When she felt cared about, because she knows I go to some monthly meetings to learn more.

She says she feels a connection to me when she knows I'm at those meetings. And it's a comfort to her. And she does not immediately follow that up with some sort of undoing, which I find positive. She's more expressive about acknowledging and seeing there's something good here. I'm comparing to perhaps a year ago.

### The Fountain

Here is a clinical pair discussing a visualization that has been important to their therapeutic work. Early in the interview, Subject 4A begins to talk about her current work in therapy.

I haven't been able to cooperate. I'm working on going to, working really hard on trying to have, an internal fountain, sort of a magical fountain that all my parts go to. I mean, they have gone to a place where they, they all know of each other and they all respect each other and want to work together to heal the system. I can envision them and they go to the fountain to meet and just to gain energy from the earth and from the heavens and the skies, sun, and just to support each other. But I'm not as able to do that on my own, so it's still I, sort of, continue to fall back into the same patterns. But I'm working with my therapist on trying to have them be conscious in going to the fountain, having them all go to the fountain and communicate. So, to try to, sort of, break away from that old pattern.

Here is her therapist, talking about the same therapeutic experience. Subject 4B says:

She has had a system that was all about divide and conquer. I think that another piece that's allowed that delight that my client was having in her relationship with me is that there feels like more of a collaboration. Between the extremes of either being that, uh, crushed with the spirit or the raging, but also isolated, disconnected, is this idea of collaboration, that her feelings and thoughts matter, that I'm interested in them. She had this image come to her that she called going to the fountain. All of her parts can meet at the fountain. We've worked together with the image of the fountain. I think it's given her a sense that she is not alone. And I'm so inspired by her, which I've told her.

### An Entire Parallel Process

Narratives again and again told the same story. What specific themes subjects chose to elaborate crossed over between therapists and patients. Clinical pair 6A and B both talked about the tragic loss of the patient's wife and baby in childbirth. They both went on to talk about the ease of the development of their therapeutic relationship. They spoke at length about how he was neglected and abused as a child, and the terrible difficulty he has had in developing trust in relationship. They both concluded by talking about his life now and his recent involvement with patient advocacy. He says:

I felt scared, alone, abandoned. [Deep Breath] Hated, completely alone in the world. I still feel like that at times. I do. I still feel very much very scared of this world. It's a scary place, still very scared. That's why I love going to see L. I see her, 'cause I feel completely protected there. And I know she won't let anybody hurt me or anything bad happen to me. I'm a lot better than I was when I first came in. I'm further along; now I get a pleasure out of going to, being in NAMI. I don't know if you know, National Alliance for the Mentally Ill.

I go, I just started, went to my first walk last year; we'll be doing it again this year and, uh, went to Springfield a couple of weeks ago for rally for the, for funding for the mentally ill. I get pleasure out of that stuff, doing that, 'cause I have a, I can actually have a voice now and I can give my opinion about that and speak up for people that have mental illness just like me or who've been abused like me. I can actually do some good out of it and I get pleasure out of doing that stuff; makes me feel good, makes me feel good, makes me feel somewhat like I'm okay.

His therapist says:

Oh, and I forgot another thing, just thinking a pleasurable thing. He's involved in NAMI and did a walk for them. He loves doing that kind of stuff; he's changed. He did that for two years in a row now. I think that's really helped him to own more that he has a mental illness and that the stigma has lessened for him and he wants to be a part of positive movement. So that's something. The National Association for Mental Illness; I think he's gotten involved with some peers and they've gone to Springfield and tried to march for rights for those with mental illness and, so I think that's been, that something that he's done on his own. And he loves it, you know, he comes back and he's telling me all about what's happened and I think it's enjoyable for him to be part of something positive and through his own initiative; it's fantastic, really. And, you know, we do talk about what, that really feeds him, that that's fun for him that he gets that. That helps him

manage some of those feelings of anger and especially the anger and rage, he can connect with other people and be a part of something positive.

Both therapist and patient were speaking in response to minimal prompts. They were both asked to discuss the patient's experience of pleasure. Neither was asked to tell his trauma story. Though both were asked how the therapy had affected his experience of pleasure, neither was asked if there were new activities in his life or if he participated in any political action. It is worth noting, also, that this is not a recent development in the life of the patient. He has been working with NAMI for 2 years. Yet on the days they were interviewed, both told me this part of his story. This pair, like every other pair, interviewed, showed this narrative linkage.

#### Artists at Work

One therapist interviewed used art therapy as a predominant modality. This therapist talked extensively about her use of a variety of artistic media to engage her patient. The researcher expected to hear from both patient and therapist about this modality. It was not expected that they would both choose to tell the same story about one particular piece of work they did together. The therapist told me the following story.

She was drawing; she was at a carnival recently and it just triggered a lot of bad memories. She'd had some bad experiences at a carnival. And so I, and she was in the child part, she had been talking about it as an adult and then she dissociated into the child part, and I had her draw and she drew this kind of a picture of the carnival and where she was and what was scary.

I can't remember exactly the details of it, but that there was a tent, or, like a working area where bad people would bring children into and abuse them. I think her uncle knew someone there and brought her in there. And so she knew, so that was a bad part of the carnival to her and had a lot of anxiety. So, it was like this map, sort of, looking down on a carnival; this bad place is over here and, like, a ride is over here.

I'm not sure what made me say this, because it isn't typical for me to say, um, but I said, how can you, and the picture was disturbing to her and it wasn't working, she wasn't feeling better. And so that was not pleasurable. [Laughs] So I said, is there a way of making this better, somehow? And, she started covering up, I have to look at the picture again, but she started transforming it into something better.

Over this black part was, like, water, it became, maybe, a water ride or something or it was something pleasurable for her and the parts. I think there was a big "X" across this other bad area, that you couldn't go into, it became a protective barrier. We talked about it in terms of being a protective barrier. So, she transformed the picture into something that was more protective, more relaxing and enjoyable for her.

This therapist's patient told me the same story in this way.

My daughter will say she's never been [to] an amusement park. There's some things I can handle with her and have fun with and there are some things that we can't. So we went to a carnival. My daughter and I just last month before they were closing and I hadn't even remembered, I haven't remembered being there as a kid. But I remember the good and not the bad, so I had just blocked it out. Well, this was about taking my daughter and going with her and having fun and everything was going great, 'til I got on one ride and then all these memories came back. And, so, it was like that took the pleasure out.

My therapist and me, I didn't think it was possible, we took a picture and I was just drawing of it. What I was drawing, it was with a carnival and I was drawing what I remembered. And I switch into one of my child alters and drew this picture.

Okay. I don't know how J. does it, but she talks to this child and by the time I come back this awful picture is like a hut on a beach with a lawn chair and is, like, something really bad got turned into something good. This really bad memory got turned into something safe and couldn't hurt me. Wow, if an inner child's capable of doing that, what could I do!

Additionally, this same clinical pair both told me this broken glass story. The therapist first explained to me how she arrived at this idea. She says:

There was a project that I found out about where people were doing jars. People were doing jars or this person was collecting jars for a project in the art therapy program. And it was around wanting to have all these jars expressing trauma and the strength that a person comes out with through the process of having experienced trauma. So I asked her if she wanted, I told her about the project. I

gave her the flyer and asked her if she wanted to do it. Work on this and that, it would be, I think, fun to make the jar. Even though it's about a difficult subject, but it also would be doing a lot of good because it's for people to come and see and to make people aware of abuse, sex abuse, and so it's doing good at the same time.

So, she decided that she wanted to do it and so we worked on it together, um, I helped her with her jar, more as just, kind of, helping her through the process of doing it. Although, I can't say she liked her jar. There were different parts of her that had different experiences with it and she likes it. But she's uncomfortable looking at it, sometimes.

Well, she was layering it sort of, it reminded me of these kids who are like layers of sand, and so it reminded me of that all those layers of glass and stones. And she had some pieces that were too big and so I got a hammer and had her break the pieces. The big pieces into little pieces and she really liked breaking the glass. And I did it so that it was safe. [Laughs] Um, but that was enjoyable and she said, you know, she really liked doing [Laughs] that and so, just the act of layering it. And then I think it had some red pieces in it or something that she didn't like that were a little scary.

So then we would figure out how to make that feel better by, maybe, layering with a different color. And then on the top of it she, um, put, well, this, this was a glass tube that fit through the whole thing so that it and it symbolically I think it had to do with, um, this core both going down and coming up. That had, like, this, she made a rainbow star out of the very top that came up and so there was hope and there was this solidness that, kind of, went down and back up again.

Patient-subject 13A tells the same story much less elaborately, but with the same gusto.

I think, what, I don't, I don't know if I can really put pleasure and therapy in the same sentence. It's like military and intelligence. But, I think, a part of me says yes because, like, it's okay to color, we do art things and I'm finding out that, like, some of these big dark secrets and things that I thought were so wrong aren't really wrong with me. You know, and we find that out, like, we did, um, a jar. We made jars.

And that, that was kind of neat because we broke glass, we painted, what else did we do with it. I don't know, like, you can do things. And, like, for me, until therapy, if I couldn't color in the lines and it wasn't O— And just doing that, I don't know to explain how, like getting her permission to do that is freeing to do more. We just picked the colors in advance and it turned out beautiful and I did it,

I mean we did it. She helped, but I did, you know what I'm saying, for all purposes it was mine.

### From Fantasy to Reality

Clinical pair 8A and 8B both told a moving account of the patient's progression in therapy from the containment of her pleasure within her fantasy life to her gleeful pursuit of adventures in the world around her. Prior to entering therapy, they both described the patient having a rich isolated fantasy life in which she rarely left the apartment. She had two grown children and was already a grandmother when she started therapy. The patient-subject described her situation in the following way:

They were like the best little kids and we would play. I would in my, in my world, in my safe world. I would never go out with them, but we would, I would create, like, all of these places in, inside the house. I would, literally, like, turn my living room into, like this, the best world ever.

You know, we always went on trips, we would spread out our circle rug out and, so where we going to go today. I said, I know what, let's go to Hawaii. So I would create Hawaii and we would be in Hawaii and all the little hula skirts and the little everything and so we would sit and fantasy play.

But when they weren't there, it's like, I've been, I would be inside in front of my window like a little kid, just looking out, it's like, wow, it looks like their outside, you know, and then, like, they would see me in the window. It's like, come down. No. No. It's like, are you okay? It's like, maybe one day I'll, you know, it's like, oh wow. I really would go down there, but I'm afraid. You know, so, it's like, I was always peering out of the windows. [Laughs] Never just, and, like, I would come out on the back and I would look up at the sky and just watch the clouds form, like, little, it's like, oh wow, they look like cotton balls, it's like a really big cotton ball.

And then, watch the sun set. But, I would never just be out or go out. It's like, they always would invite me to go places. It's, like, oh, oh girl, I'm just really busy. It's, like, what are you doing, what are you doing? You know, but I was just afraid to go out there because I think I had just scared myself to, to believe that. It was very scary, you know, outside, outside, it's not where you want to be.

Her therapist told me the same story in this way.

D. didn't really interact with other people, she, um, except for family. So, she didn't, like, go out and socialize, she didn't even interact with the people in her building and she's lived in the same building for, you know, over ten years, maybe twenty years, I can't remember. And, um, and she didn't interact with any of those people. She would stand at the window and look out, though, that's something that, as we started to realize and talk more about.

So, it wasn't like she was alone. There was, kind of, a longing that we were able to finally identify that she would stand at the window and look out. So I'll talk more about that in a minute, but what I really feel like, was slow to realize, is that she had this fantasy life. She had her own world. And it really was a fantasy and she spent many years in it with children then grandchildren. So, she would create all these elaborate fantasies. They would travel everywhere. They went to all kinds of wonderful and magical places and in this world she would create with them and that was her pleasure. And, and it definitely gave her pleasure and then she very much enjoyed it. But it was like a bubble.

Both the patient and the therapist went on to tell me this story of her freedom. The patient said:

We have talked about things. So I was like, oh wow, you know, I've been missing out all of time. Now the adventures and how it feels to be out among other people and not be scary. She asks, what was it like when you went out? What was it like with a lot of people, lots and lots and lots of people? I was, like, telling myself, I had to tell myself, it's okay, it's okay, because I didn't see an exit. I couldn't visualize an out.

That was my biggest fear with the crowds is you gonna get really trampled on and you gonna die. It's like all these people and there is no way out, oh my God, but at the time I went it was crowded, but it was earlier in the day so it wasn't as crowded. Then as we were beginning to leave, it got kind of really congested. I was amazed at, like, the mass of people. Oh wow, this is what people really do for fun! It's like, walk around, you taste this, you taste this, I guess it's just the feel of being outdoors, you know, just socializing. I enjoyed it. It was scary for a moment, but I just kept telling myself that, you know, everything it gonna be okay. No one else is looking for an out.

So then I went to the zoo. And it was really good to see the animals, you know, because I'm a, I'm a very, I like nature. I like, um, I just like the outdoors, but I didn't want to come outdoors. And one time my friend got me to go at the beginning of fall, as the leaves change. We were picking up leaves, like the different color leaves, and he would write poetry to it. Like, this leaf represents this. And I was like, oh wow, and that was, like, the best, just looking at the changes of the colors of the trees; I was like, oh wow, wow!

Her therapist told me the same story this way.

What she's very clear about now is the huge difference between now and then. She's very smart and very creative. She's very funny. But she just didn't interact with other people. We just started to talk about it. Kept talking about what would it be like if you were around people. She would say, I'm afraid I'd say the wrong thing. We would talk about, how wrong could it be? You and I chat, you talk with me.

We kept kind of, playing with that. And, honestly, this was, kind of, out of the blue, I don't know how long we'd been working on this. You know, a while, but I came in one day and she said, um, I went to the downtown. And I said, you went downtown? [Laughs] I asked, when did you go? You know, on the fireworks night. I was like [Laughs] on the fireworks night! It's, like, my God! She was, like, we had a great time, we had so much fun, oh, but this one thing happened. There was kind of, a riot. All the crowd running and them holding hands to try to stay together. She talked about starting to freak out, but she was able to talk herself down. Her whole feeling ended up it was really great. And I just felt like someone had run over me with a bus, I was, like, what! [Laughs] Where did you come from?

And then she just started doing things. She took a bus and went to visit a relative in Michigan and she loved looking at all the sights. And she came back telling me about, she saw cows on the lawn. She and I still love to talk about that one. Her grandmother and some of her kids and tons of grandkids, they all went to this water park and she had a great time, a fabulous time. She went to a baseball game with the church. And she liked it.

### *Discussion*

The interviews are not only replete with specific parallel stories, the emphasis, cadence, and emotional tenor is recognizably unique to each clinical pair. The fact that these patients chose to participate in this research with their therapists is an indicator of the value of the work they have done together and the depth of their relationships. This connection can be seen throughout the interviews in the unique voice of each dyad.

Therapists who laughed a lot in the interviews had patients who laughed a lot. Therapists who spoke cautiously had patients who spoke cautiously. The only patient

who spoke extensively in detailed descriptions of her abuse had a therapist who also felt compelled to make me understand the specific horrors of her story. Neither of them, subjects 14A/B, ever laughed during the interviews. Their joint demeanor was solemn throughout. Although subjects 8A/B spoke seriously about the patient's problem, they both were playful and laughed a lot. Subjects 1A/B were both serious and spoke cautiously. Subjects 10A/B were both exceedingly bright, reflective, and articulate. Both subject 6A and 6B cried during the interviews, and so did I. Although I teared up at moments in other interviews, when subject 6A stopped speaking, I burst into tears.

Therapists and patients in the same dyad did not necessarily come from the same socio-economic strata. They were not always of the same sexual orientation, religion, race, or gender. Yet they were unmistakably "couples." Their relationships with each other were so palpable to the researcher, so distinctly flavored, that amidst conducting over thirty interviews, the researcher never confused which therapist belonged to which patient, not even for a moment.

## CHAPTER VII

### OUT OF FRAME

#### Introduction

The need for both a therapeutic alliance and a clear treatment frame, says Moorey (2006, p. 241), comes from “principles which were originally developed within psychoanalysis that are applicable to any form of ‘therapy.’ As we shall see, attending to the frame and the alliance is essentially about being clear about the parameters of the service being offered, and what is being asked of service providers and service users.” Moorey’s (2006) definition of the treatment frame both implicitly argues for the importance of maintaining a treatment frame and the need for clarity and specificity in how the treatment will and will not be offered.

There is a long tradition in the field stressing the importance of maintaining an ethical and therapeutic treatment frame. There is also a long debate about what should be the parameters of this frame. Langs (1979) argues for a secure, reliable, and static frame. Casement (1985), while agreeing as to the importance of the frame, argues for a responsive frame created by the careful, reflective process on the part of the therapist to each particular patient and the moment being engaged in the therapeutic process. These are two polarized positions on a spectrum of thinking about treatment technique. The therapist-subjects all clearly spoke of their belief in the necessity of a clear treatment frame. Although all psychodynamic practitioners, they varied in the particulars of how

they constructed that frame. Of note in the data was the number of therapists who commented on a particularly significant therapeutic moment of engagement outside their normative frame.

For every therapist-subject who told an out-of-frame narrative, their patient told their own version of this *same* moment. The same moments that surprised the therapists were experienced by their patients as pivotal to the success of the therapy. The patients reported experiencing great pleasure in this responsiveness from their therapists. These are moments in which patient-subjects often felt cared about in ways that were new and unique to their experience of relationship.

#### Tea for Two

This therapist-subject told this narrative spontaneously early in the interview. She was responding to being asked to discuss her patient's experience of pleasure. She describes her very conscious creation of a unique pleasurable ritual with her patient. It is not part of this therapist's normative frame to have tea with her patients. She has given a lot of thought not only to this tea ceremony, but to her therapeutic rationale. Subject 2B says:

One thing that I have done in particular with her is we have a ritual [Laughs] in the therapy which involves my preparing tea for her. And I do it consciously, on a plate of aluminum, an old aluminum tray that my mother had that has fine things on it. And flowers and that's the tray that I carry things on. Her job as she comes into my office, she takes my little table that I have beside the sofa, she puts it equidistant between the two of us, which is her contribution to this. So, I bring out cups of tea, cups of water, hot water with, and I choose a little bowl, a little tiny, like something that she might put soy sauce in for sushi or something. I use that for the teabags and I bring out three packets of Sweet-N-Low, actually, Splenda.

And, a pitcher, a little tiny pitcher of milk and two tea bags and we generally have, um, Earl Grey. And, so, that's the way we start every session, with that particular array of things. And, then it's, it's sort of, getting into the

session where, where she comes in and no matter how she's feeling that day that ritual kind of connects us.

And then through the session, and we [Laughs] may comment on the tea, how, how the tea water got poured and spilled or [Laughs] in the kitchen in my bringing it out or this or that or the other thing. So it's actually the segue into the work.

I believe it certainly gives me pleasure, but I see in her face the pleasure that it gives her. Um, and, and, and I think the, the tea is something that is also pleasurable, just the tea, just knowing that she can count on it and I can count on it. I think she, she gravitates more toward the pleasurable than the dark side. But it's like the darkness in her family just kept, you know, bringing her back down out of that, pulling her out when what she really wanted to be was unencumbered by all of that stuff so she could be who she is, which is a joyous person who brings joy to others.

And I feel I'm on a ride, enjoying her pleasure unequivocally. And in a way that's, kind of, my role is really not to sabotage or destroy her pleasure, which is something that was done to her. And, it was turned around, it was used against her brilliance and her sunniness, her joys were, were used against her in extremely unfair ways.

She is creating safe pleasure. Both the therapist and her patient explained to me how pleasure in her childhood was an overture to injury. The experience of pleasure between this clinical pair has been a platform from which the patient could begin to launch her own explorations of pleasure within a safe relational context. When the patient originally presented for psychotherapy, she was dating a man who physically abused her. Here she tells about the first therapy session and the beginning of their tea.

I actually started going to my therapist because I was worried about my boyfriend. [Laughs] And he wasn't going to a therapist like he should. I felt that he was lying to me, so, I said, well you know what, we're having problems, let's go to a couples counselor. So, he found her. We went in there and she was the one that was like, you can't be together. I'm sorry, you know if you guys want to stay together, but I cannot treat you two together as a couple. This is toxic and I can't see this happening. And, so, I will treat you separately, I have no problem with that, but I cannot treat you two together.

And, so, he left first. He felt like he needed to leave first. So that was fine, um, but, like, once he left she just asked me if she could hug me. So she basically

just held me while I cried. Then she made tea for us. We always make tea now. [Laughs, pauses.]

I didn't want to take public transportation. We had taken public transportation 'cause he didn't drive and I didn't have a car at that point. I was still in college and I just didn't know where I was and I wasn't about to find my way back to the El and I was just like, I don't know what to do. And, so, [Laughs] I said, the only thing I have is the credit card that my dad gave me, but I can't use it because I'm only supposed to tell him when I need to use it and I don't know how much money I have on there. And it was really only for books for school and I'm done with school, so, I don't even know how much money's on there. And so she suggested that I use it, because my [Laughs] I forgot exactly what she said, but basically, because I was there because of my father, anyways. So he [Laughs] could pay for my cab ride home. So she called a cab for me and, and it turned out that the only one that was available was actually, like, this little, like limo town car thing. And so they drove me home, and I didn't have to worry about the money that I paid because it was my dad's [Laughs] and I didn't have to worry about that.

So we wonder why tea holds so much importance between this clinical pair. Subject 2A explains her initial amazement with her therapist in the context of her life experience in the following excerpt. Seen within her life experience, the importance of her therapist taking the time to arrange this concrete pleasurable experience is illuminated. She says:

The first thing when I was leaving, she just told me to be kind to myself. And I, it's like, huh, I don't know how to do that [Laughs]. Okay, well, what is that? Or that was like telling me something Greek. [Laughs] I was just like, what, what do you mean? [Laughs] So I asked her, what do you mean? I've always felt like that was sort of greedy. I wasn't allowed to do that when I was little. Like, when I, growing up, like, I was like, I'm a teenager, I should be able to sleep in, I was not allowed to sleep in any later than nine o'clock. And if I was reading a book that meant it was time to interrupt me if I was, like doing anything for myself. But, I've learned that it's okay to take time for myself, through therapy. I've learned to have tea. Because I really don't know what I would be doing without therapy.

“When Nobody Was Watching Him”

Both the patient and therapist told me in great detail about this pivotal moment in their therapy. Though it is clear that they are speaking about the same event, the specific stories they tell about their connection are very different. Still, this moment was considered by both as a turning point in the therapy. The patient, Subject 7A, says:

I do find pleasure in being with him and talking to him and challenging him and, um, knowing that he really does care. [Crying] So, there's not too many people or a therapist that really does cry with you and you know that it's genuine. I mean, he's amazing. Very amazing and I can remember when he had his aneurism, I thought we were all gonna die because it came very close to him dying.

And, you know, when you have such a close relationship like that and the other people that are managing him, people who care about him kinda took us, um, away from him. You know, they had to separate us, kind of. And I, I realize how necessary that was, but it was very painful. You know, to go from talking to him ten times a day to nothing. It was like a drug, you know, not getting that drug,

And, [Laughs] he finally was well enough to call us when nobody was watching him. [Laughs] Because I was fully told, do not go to the hospital where he is, which I would never do that. I wanted to. We all did, we all wanted to pile ourselves in the, in the car and get there as soon as possible, you know. But we didn't. But, when he was able to call, I'll never forget. It was like four o'clock in the morning. He was able to call because he knew, even when his brain was sick, he knew how worried we were, you know. So, when he called, it was like, oh my God, okay, you're alive. You're talking.

And then I felt guilty because he felt that deeply to know that that we were crazy, going crazy without him. So, you don't find too many therapists that are at that point with people; you just don't. And, I mean, if it wasn't for him, I don't know where I'd be right now; I really don't. He's been through thick and thin with us and we've been through a lot of shit. [Laughs] Now we have a past, but the, the future here and how he puts up with us, I don't know. [Laughs] I don't know, but, um, yeah so, yeah, there's a lot of pleasure with him, yeah. And he's taught us a lot about pleasure, about accepting us where we're at.

Listen to how the therapist tells the same story. Subject 7B says, laughing:

Well there was the time when I had an aneurysm. I was supposed to see her that day. Someone called her and told her what happened and that I was okay, that I'd be in the hospital for awhile. They didn't tell her where I was. When she was notified that I was in the hospital for an extended stay, she called every hospital in the area until she found where I was at. She showed up at my room very late at night. I was out of Intensive Care. Somehow she got by the nurse's station and it seemed she appeared out of nowhere. She had tears in her eyes and was afraid I would be angry. Her first words were, "Everyone who goes into the hospital never comes out."

[Laughs] I was so knocked out on Oxycotin, I didn't know what I was doing! I smiled, got teary eyed, got out of bed, put on my robe, and said, "Let's go for a walk." There was like this terrace, patio, off the floor for patients and their visitors. I sat with her for about a half an hour to an hour and reassured her that I was going to be okay and that I was going to see her in a few weeks. It was a very intimate moment. I think that very near to the end of our meeting, one of the rageful angry and hateful alters said, "Don't fucking do that again," and then we both laughed.

The therapist clearly finds himself in extraordinary circumstances. Despite his emergence, he has behaved within his therapeutic frame. He had an emergency system in place to notify his patients and had done so. He had not shared the private information about where he was hospitalized. Post surgically, he had not yet seen himself as ready to contact his patients himself. Yet he is emotionally touched by both her anxiety and her concern. He responds generously.

Despite the difference in the details of their stories, she clearly feels his generosity. She says, "So, you don't find too many therapists that are at that point with people. He's been through thick and thin with us, and we've been through a lot of shit. [Laughs] Now we have a past, but the, the future here and how he puts up with us, I don't know. [Laughs] I don't know, but, um, yeah, so, yeah, there's a lot of pleasure with him." This story from their relationship for her condenses his goodness. It is representative of something larger that she found with him. It speaks to his reliability. Moreover, she links

this with the pleasure she has in relationship with him. She can count on him. There is a lot of pleasure in that.

### “The Most Intensely Uncomfortable Moment”

As previously illustrated, the best moments in psychotherapy and the most useful out-of-frame moments aren't necessarily moments of pleasure, initially. They can be moments of crisis, which push the clinical pair out of their usual, more comfortable treatment frame. The pleasure described is often after the fact; pleasure in a powerful, unexpectedly positive outcome. This clinical pair describes such a moment when they were both moving outside of their usual and more comfortable working parameters. They tell essentially the same story, with only slight variations in emphasis. Patient 10A says:

I trust her to see things and we had an experience fairly recently that I honestly thought, I mean, I've been seeing her about ten years, um, maybe a little bit more, I just, I could not see ever happening or being able to cope with or survive. That was, she showed up in my apartment, sort of, to do an intervention. And, it was probably one of the most intensely uncomfortable moments I can remember. And yet, I think it was, it was also a breakthrough. Um, because I had let her see things bit by bit in sessions; um, we've always had, what I thought, very healthy boundaries. She's available for phone calls, but we had never done that sort of outside-the-office, in-person thing. So to have her suddenly there in my apartment, seeing me in the middle of something that I'd always very deliberately kept from people—it was terrifying. But like I said, it was fairly recent, so we had years of all these other things in place and it ended up being uncomfortable, but survivable.”

[Laughs] 'Cause she's still around. You know, there's so many different levels of pleasure. There's the level of opening your freezer and seeing that there's a pint of ice cream on that night you really wanted that; and you can derive some sort of satisfaction and pleasure from that. And then there's the pleasure that I see other people experiencing being in a deeply committed, loving relationship. Well, that's a very broad spectrum.

For this patient, the moment was not only retrospectively pleasurable, but markedly so. He differentiates a hierarchy of pleasure. This out-of-frame moment was not

a “pint of ice cream.” It was evidence of a “deeply committed, loving relationship.” His therapist seems to have a similar perspective. She says:

I think those experiences have helped him trust me more and tell me more and allow the integration of his affect more into awareness. And then another experience where he, I talked with him about hospitalization. This was maybe, I think, last year. Because he had something at home that he was gonna take or injure himself with. I can't quite remember what it was, but I said, 'Well, I won't hospitalize you if you give it to me.' And, he said, 'Okay, but I can't make it to your office.' So I made a decision to go make a home visit.

That was also very significant, I think, this whole long process of recognition and having someone share an experience and acknowledge it and help him with it, rather than push him off to someone else. I felt uneasy, you know, about the decision. But I decided I, and this is an interesting awareness that I've had over time with, that I trusted him enough.

You know, it's not just, it's not, I think, the therapeutic process is just, of course it isn't one sided. Um, so I've had an awareness. If I trust the client enough, which after, I think, and that was about 8 and a half or 9 years of therapy that I felt that I could. I knew him well enough and trusted him in our relationship that I could make a home visit and it wouldn't be a disaster. [Laughs] That what he was telling me over the phone, when we had this crisis call, was, was probably the truth. That he would give me this means of suicide if, if I could get there to help him.

That seemed very important, again, another experience of, which helped with his integration and the lessening of his pain. You know, how does, how does the pain of trauma get resolved? That's a big question.

I think he did say something later about, you didn't just send me away when I was in so much pain. Nobody was supposed to see him like that. Nobody was supposed to see these parts of him. It wasn't supposed to happen. And he felt vulnerable, but I think there was enough trust. He gave me the, the means of suicide and he calmed down. He began to pull together and become less dissociated. I think it was an experience where, um, part of the process towards more pleasure was to integrate these split-off parts.

I don't know how does it works with humans sharing, sharing their pain with someone seems to help. I think it was me, the good enough person, good enough mother, good enough therapist, um, really sharing with him. And it was difficult for me. I was so frightened and upset at the extent of his pain and sharing it with him. Not, freaking out myself.

I think, however, that helps psychically, physiologically, biologically, whatever, that therapeutic experience of, um, being with him when he was, in, sort of, at his worst, dissociated and scared and parts of him all talking to him. And, you know, different voices telling him, don't show her, this isn't supposed to happen, she can't see it, she can't see us. But he was able to articulate, after the fact; this was part of allowing him to get to a place where he can enjoy life more.

So both the patient and the therapist return to the subject of pleasure. They both speak to his vulnerability and willingness, however tentative, to have her see him in his most fragmented self. This experience of her caring, the absence of rejection, allowed him to feel the pleasure of a loving relationship. His therapist believes the same experience opened up his exploratory capacity, "allowing him to get to place where he can enjoy life more." Both therapist and patient told me about a flourishing of interpersonal exploration in the year following these events. For the first time the patient began to develop a vibrant, healthy network of relationships.

#### "One of the Only Clients"

Positive out-of-frame moments were not usually planned. Even in the tea ceremony, the therapist gradually developed the offering of a cup of tea into an elaborate ritual that she could expound upon after the fact. For most therapeutic pairs, they stumble into the out-of-frame positive moment. Sometimes they stumble in with trepidation. Sometimes they stumble in, resisting every step along the way. Here another therapist talks about a simple ritual that has developed with her patient over time. She not only discusses how unusual this behavior is for her, but additionally comments on the fact that she is doing something that she doesn't like to do. Subject 1B says:

She is probably one of the only clients, and this started a few months after we, she, started coming in, she is one of the only clients that hugs me at the end of each session. I'm not a very, um, physical person, just in general. [Laughs] Like I'm good. It always comes as a very natural part of the end of the session. And it doesn't feel unusual for us. But especially for me; I probably had to question this when it started happening. I probably was asking my colleagues who I practice in the same office with, like, are my boundaries okay here? This seems really too much, like, too intimate, too close, but it doesn't feel weird at the time.

It took me a while to kind of figure that out, a bit. Really, what I've kind of come down to is that, it works for her and I. And this I find very unusual, that she kind of brings that part out of me. That I would never have, that I don't usually. The most I do with most clients is a handshake, and that's only if they instigate it. [Laughs] I'm good, I'm good I'm over here, you know.

It's as though she needs that kind of actual physical closeness with me before she leaves. I think she experiences throughout the session that I'm going to just jump up and run out. That I'm not going to be able to stand it. But then, when we're going to leave, it really helps kind of solidify things. She talks a lot about being afraid when she tells me things she's not told before. And she frequently asks me, is this okay, is this okay, which I just think is so smart. She's afraid that she's told me too much. She says she has a hard time looking at me when she leaves, and so that's sometimes helps her to hold onto me for a little while and then she'll look at me.

It also has a very child-parent feel to it, to me, which is maybe why it doesn't faze me as much in terms of intimacy. It feels very much more of a comforting aspect than anything that I would worry about as being maybe sexualized. Yeah, it's kind of interesting. She always makes me feel very tall, very parental. I know the horror stories about her mother.

I don't know all of what her mother's relationship is based on. But in part, it's based on the client always taking care of the mother. And I know there's a part of me that really wants to [Deep Sigh] really console and in some ways that I'm, you know, I'm very aware of my feelings in that regard, this trying to kind of create a relationship that is based on trust and, you know, caring and not on [Sighs] her taking care of me.

The therapist's discomfort is palpable throughout the narrative. She is not a hugger. She doesn't think it is necessarily a good idea to hug her patients. She worries about doing injury. She wonders about the meaning of the ritual hug. Even when she is satisfied that there is a good therapeutic rationale for hugging this patient at the end of

sessions, even when she determines that she will continue to do so, she is not comfortable. She is willing to be uncomfortable because she believes that hugging this patient is therapeutic. She is still out of frame. Reluctantly, she has accommodated herself to staying out of frame in this particular way with this particular patient.

### Kicking Her Butt

Here, again, a clinical pair talks about a pivotal moment in therapy. An assertive, but mild-mannered psychotherapist demands that her patient stop drinking. This behavior is out of frame for this therapist, who has informed me that she thinks rigid treatment protocols for alcoholics are untenable. She treats addictions flexibly, assessing what she thinks is necessary in each individual situation. She thinks that addictions are ways of managing pain and suffering. Normally, she would be addressing the underlying issues that prompt the behavior. Here, spontaneously and to her own surprise, she “kicks butt.”

When she came into therapy with me, she was actively drinking, on the verge of suicidal, um, full of anger, very depressed, full of anxiety, um, you know, hitting walls with her fists and practically breaking her hand. I mean, way out of control in her alcoholism and, you know, her depression. She hadn't dealt with any of the incest. I don't think there's any pleasure there.

I think there was pain and relief from pain. I don't include when somebody's drunk or high, that experience, I don't put that in the category of pleasure. I don't care that there's more dopamine being released, you know, if you're not an alcoholic and you have a drink at a party and you relax, that's creating some pleasure for you.

When you're an addict and you're using, I don't put that in the category of pleasure at all. And, generally, that's not the intention and, generally, she, I think she would say this and has said it to me that was not her goal. It was to get drunk. It was to get blasted. It was not having pleasure; the goal was relief of pain.”

At a certain point I basically said, had to say to her, you know what? If you want to keep going out drinking, go out and drink and come back because you're wasting your time. And I don't say that to everybody, you know, some

people that work with addiction, that's like an automatic. And I I don't work that way. I do it on a more case by case basis. But that is what I told her.

She tells me this story 20 years later. [Laughs] She tells this story and she cracks up now. I don't even remember how it came up. She was remembering that story of how I had told her that you know, toward the beginning. And I don't know how I knew at the time. And I like to say, it's not something I do automatically. You know, it's not like, well, if you don't do this, then I do this. I really do it case by case. She remembered it and it made a big difference in her case. You never know who, right? You never know. But, in her case it did, and, I mean, she did get sober very soon after that. She didn't want to quit coming.

Clearly, this was a pivotal moment for both therapist and patient, because they both told the story of what happened between them that day. Again, this therapist's out-of-frame-moment proves to be critical to the therapy. Here is her patient, subject 5A, discussing the event.

I knew no matter what happened she was never going to abandon me. I knew that no matter what happened, she's never gonna get angry with me. You know, at one point, I started heading downhill again and it was early in therapy. It was pretty early on in therapy. And I started to really pick up my drinking, which was bad, because unlike marijuana, I lose control. With marijuana I could have the sense of control. I'm really stupid, but [Laughs] I have the sense of it. [Coughs] I had gone out the night before with some friends and really tied one on. And I drove home in a blackout and she had given me an eight o'clock flipping session [Laughs]. It's like she knew, she knew what I was doing. It's like she knew and I showed at the session and I was still all hung over. I had gone home. I hadn't gone to sleep. I showed up at the session. I showered and everything. I tried to eat something before I got there. I was still intoxicated. I reeked. I reeked, literally, of scotch. I mean, it was just a bad night. It was just a real night of, okay, who can drink more than whom. And, uh, she really put her foot down and she said, if you're gonna continue to use, I'm not gonna treat you. And she meant so much to me that I stopped. That I went, I stopped drinking that day.

I didn't pick up another drink for, you know, for years. Ten years, I didn't pick up another drink. Because it, she meant that much to me, that we had established that much trust that I knew she wouldn't abandon me, I knew she wouldn't hurt me and I knew that she wouldn't cross that boundary like that. I couldn't risk losing her. And I, to this day, I can't risk losing her. Um, so I was, was just, did what it took to not lose that.

And then the pleasure of therapy now, I mean, I never go there and feel like I'm sitting with a good friend, I mean, I, you know, I don't feel that way,

although I wish it was that way, I wish that I can, you know, have that good friendship with her, but I do feel like I get to go to see the one person that I totally love for an hour a week. That I would, I would trust with my life because she's saved my life, I mean, she saved it in, in respect that she taught me how to save my life.

Perhaps a viable treatment frame is not a rigid set of rules, but includes both non-negotiable and negotiable, conscious and unconscious boundaries. The intention of the treatment frame may be twofold: to create a safe relational space for human interaction and define the parameters of a therapeutic relationship. In a classical Freudian analysis, the treatment frame includes the mandate that the patient say everything on his or her mind, free associate. Freud (1913) considered this non-negotiable. Ogden (1996) argues that this non-negotiable can become a hindrance to treatment itself.

The subjects in this study, both therapists and patients, tell stories not of therapeutic impulsivity, but responsiveness. These therapists do not step out of frame easily. They are mostly reluctant and always thoughtful about their movement outside of their normative parameters. The therapists are attuned to their patients, responsive and reflective about what they are doing. Much like Ogden (1996) and Casement (1991), they do not give up their treatment frame; they alter the frame to fit this moment in the therapeutic life of the patient. They exemplify the difference between reactivity and responsivity.

## CHAPTER VIII

## REPAIR: "EVERYTHING IS POSSIBLE"

Subject 1A's description of therapeutic repair is imbued with pleasure. She smiles as she says:

Therapy just seems like it makes things possible, because when I'm having a hard time, I just knew things were affecting my relationships in my life and I didn't want it to do that anymore. And I was having a hard time, dealing with my illness and the abuse and stuff. And so it was like a haven. It was really good. It was something I finally did for myself. She's, you know, one of the first people I really feel safe enough to even talk about any of these issues; when I'm there everything is possible.

I feel free there. I feel like there's a big weight lifted off my shoulders. I have this wall around me, but when I'm there I don't feel like it's there [Laughs, breathes deeply.] It allows me to remember stuff and see things that have happened and not be afraid. I'm not afraid to tell her what happened and I guess that with the other people I haven't really been able to get out. I feel stupid at times and I'm ashamed that I've let these things that happened so long ago still bother me, and when I'm there I don't feel so stupid, I feel like things are possible. I have hope.

Safety, freedom and hope all give her pleasure.

This population of subjects did not enter psychotherapy thinking that "everything is possible." They did not present because they wanted to expand their human potential. They presented because they were in pain. All of them had previous, unsuccessful psychotherapies. Some previous psychotherapies were reported as harmful. Most of them had originally been symptomatic as children. All of them had originally sought treatment

in adolescence or early adulthood. (See Appendix G) Not until this psychotherapy did they feel they had been helped.

So, is pleasure important in the therapeutic paradigm of repair for survivors of chronic childhood abuse and neglect? In this study, all subjects endorsed both the idea that the capacity for pleasure was essential to healing and that pleasure itself was problematic. Therefore, in this chapter we will discuss the importance of pleasure to these subjects, review how pleasure is problematic, and then discuss what they found therapeutically helpful in repairing their difficulties with pleasure. Their therapists' perspectives on what was helpful will be compared.

### The Importance of Pleasure

Subject 5B beautifully states the dilemma.

I think pleasure is a piece of fulfillment in life. And I think it's the, the capacity to feel pleasure is a, I'd say, a key piece, because if I can't take pleasure in anything, then how do I know what has meaning then for me? What is motivating, what creates meaning? You know, even if I'm doing something supposedly altruistic, why am I doing it? At some level it give me pleasure; at some level I feel pleasure in feeling good about myself or I feel pleasure that I'm helping somebody else or I feel pleasure that I'm being, you know, giving back to the world, whatever it is, right, my values. It seems to me very basic to that sense of fulfillment, very basic to enjoyment of life.

What Subject 5B articulates so clearly is echoed throughout the interviews by other subjects. Whatever their specific longings and desires, the fulfillment of these are inextricably bound with pleasure. The many subjects who wanted a sense of safety in their lives felt that safety itself was pleasurable.

Subject 7A describes her life filled with conflict and crisis. For her, the resolution she longs for is in “things going smoothly; maybe there’s a peace about it that brings pleasure.” Another subject describes pleasure as comfort. Comfort is essential to her. She tells us that comfort/pleasure has been crucial to her life experience. “We’ve always been that way our whole life; when, if anybody threw a little snippet of comfort our way, we would latch onto it and try to hold onto it real tight.” Pleasure is linked to sustenance, to well being.

Subject 2B says, in speaking about her patient, “I just think, naturally, as a person she wants to be joyous.” Subject 6A echoes her sentiment. He speaks eloquently in his simplicity, “[P]leasure means good; I think something that makes me feel happy, joy, contentment. When I laugh, I feel pleasure. I love laughing. One of the greatest joys of life is laughter, I think.”

These subjects did not think pleasure was irrelevant; they thought it was critical. “When I started therapy,” Subject 8A says, “I had no pleasure. I was struggling with depression. I had gotten to the point where I was just really, like, suicidal. Other than my children, I had no reason to live.” Responsibility has kept her alive. She did not want to be alive. Consistently, wanting to stay alive was related to pleasure or the hope of pleasure.

Pleasure was considered vital. Many subjects were finished or far along in treatment. These subjects reported a great deal of pleasure in their lives now. Other subjects were midway on their journeys. They still struggled and often experienced pleasure as most important of all. Subject 14A was very interested in the topic of the study. She said, “I don’t want to die until I have figured out how to solve this, how to get

better, how to find out what you're talking about." Whether they felt their capacity for pleasure had been restored or felt they were still struggling to experience much pleasure in their lives, these subjects were eager to participate in this study, because they both desired pleasure and they had found pleasure problematic.

### How Pleasure is Problematic

Patient-subjects had a longing for pleasure. This longing was not without problems. These problems are elaborated upon in Chapter V: The Disrupted Story. It is only important to rearticulate here, because these subjects linked a successful therapy completion with the restoration of the capacity for pleasure. Because these subjects thought pleasure was important, and because these subjects described significant problems with pleasure, it is not surprising that therapeutic repair was often defined in terms of the restoration, renewal, or expansion of the capacity for pleasure. Those subjects who felt less finished with their therapies were still hoping to solve the problems they had with pleasure.

Many subjects talked about a history of difficulty taking time for themselves. They usually knew what their interests were, but had had difficulty pursuing those interests. They had been ashamed of their desires and felt guilty or indulgent when they pursued what they wanted. They longed for safe and loving relationships and had been unable, most of their lives, to engage or sustain such relationships. Pleasure itself aroused conflict. They felt depressed, bereft, empty, and sad about not having been able to hold the experience of pleasure. They often felt scared, guilty, and/or ashamed when they did

experience pleasure. Pleasure was complex, riddled with discomfort and longing. Pleasure was desired, but problematic.

### The Construct of Repair

What happened in these therapies that positively impacted the patients' elaboration of the capacity for pleasure? Ehrenberg (1992) makes a theoretical distinction "between theory of technique, which relates to what we do with awareness and intention, and theory of therapeutic action, which has to do with what is healing in the psychoanalytic interaction, whether or not it evolves from our "technique." Theory does not perfectly map onto reality.

We will hear in this chapter more therapists discuss technique than patients. Examples will be given of both what therapists and patients thought were helpful. Some are derived from conscious attention to technique. Other examples are derived from elements of the therapeutic action. We will see that for patient-subjects, these distinctions often blur. Even for therapists, a crisp line between therapeutic technique and therapeutic action was not cleanly drawn between these deeply interrelated areas of the work.

Beyond therapeutic technique and therapeutic action, this chapter discusses elements of the therapeutic relationship that arose in the interviews as essential to therapeutic repair, that which therapists and patients retrospectively thought was helpful. These discussions pivot upon two bidirectional propositions. Subjects discuss how therapeutic repair enhanced their capacities for pleasure and how pleasure enhanced their capacity for therapeutic repair.

### An Example of Technique

Here the therapist, Subject 1B, talks about a moment in which she invites her patient to wonder about the transference implications of what she is saying. The therapist is aware that her patient's anxiety and related devalued self-image are being constructed within a projection of her mother's voice upon the therapist. She invites her patient to wonder about her relational expectations and, in doing so, opens up the possibility of something new in the room. She says:

I think she was waiting for me to think that she was somehow at fault. And she was so ashamed to tell me and so worried that I would think she was stupid or dumb. Oh, it was just, it was so heartbreaking. You know, to some extent that after this time, I was like, do you hear telling you that you're stupid? And she said, no. I said, well who's telling you that you're stupid? [Laughs] 'Cause those aren't my words; I would never say that. You know me well enough by now. And she, you know, she was like, oh it's just, it's just everything I think about myself.

The patient talks about how this type of transaction was useful to her. She is talking about her cumulative experience of interventions, like the one example given by her therapist. She says:

I have a hard time getting things out of my mouth [Laughs] sometimes. She's patient and kind and she's always reassuring me that it's okay. 'Cause I feel very stupid sometimes, 'cause I can't say things. I know I probably bug her because I always ask her if it's okay that I say these things or tell her these things. I know I repeat myself.

Her anxiety still pervades the interview. She does speak hesitantly and needs much encouragement to finish her thoughts. And she does repeat herself. She beams when she tells of the pleasure that she can keep asking her therapist what she needs over and over again.

And I can keep asking her. And [Laughs] she doesn't think I'm crazy! You know that I kept asking her the same thing. 'Cause I had told my mom, you know, what had happened to me. I think she cared, but she just told me there's certain things in life you just have to get over. And, uh, so I thought, OK that's what I have to do, I just have to get over it, but I didn't know how to do it. And I never told anybody else. After that, 'cause it kinda just shut me up, I didn't think I was important enough for somebody to want to help. I thought was stupid.

Clearly being able to enjoy life did not emerge from one therapeutic transaction.

For this patient, beginning to feel like she wasn't stupid for feeling injured was critical to repair. We might imagine that the problem with her mother is more pervasive than this one exemplar. And, in fact, this subject discussed her mother's unpredictability and bizarre responses extensively in the interview.

The theme of differentiating her therapist from her mother is sprinkled throughout the interview as a precursor to being able to feel safe and experience pleasure. And over and over again throughout the interview, in speaking about her therapist, she said, "I feel safe. There's a connection. And when I'm scared I guess I don't feel so scared when I'm with her. And that's a gift. I mean, to be able to have that, to feel safe."

So where does feeling safe lead her? The subject says, "I think that's what it's all about, to be able to experience pleasure to enjoy life. That's what I meant when I said quality of life. I've been given back my life. I don't want to live it just being afraid all the time. I want to make the most of it."

### Consistency and Affect Regulation

Here is another clinical pair talking about the quality of the relationship that was reparative. They say very little here about technique, though it is clear that the therapist has given a great deal of thought to what she thinks is therapeutically useful, including

her own consistency and her ability to help her patient “integrate warded-off, painful affect.” The patient-subject says:

One of the most valuable things I learned in therapy, especially working with C., as she was very consistent, was that what made me happy made me happy. The single most important thing that she has given to me is consistency. It’s probably difficult to be too specific about that, because I think a lot of times consistency, consistency means something very simple. Just being there, it’s something very basic, we’ve gone through periods, possibly long periods, where she doesn’t address a lot of specific issues. Where it’s just reassuring me that she’s still there or if I bring something disturbing, you know, to a session she’s not going to drop me as a client.

Here his therapist ponders the same question.

What aspects of the therapeutic relationship allow [Laughs] for change? We’re still working on that one. But I think very much the relationship and the development of trust allowed him to become more aware, which was very painful, of the extent of his fear and so gradually as things got more connected, as he became more connected to his affect.

Well, I guess in general, as I anticipated this interview, the concept of pleasure and what allows people to have pleasure, I think, is the integration of warded-off, painful affect—the big generalized concept. But how does that happen? Some of the psychodynamic stuff I learned in graduate school years ago, I think, is the kind of, been a core of my understanding of how to work with people. The defenses sort of got a bad name but, you know, they are ways that people have coped and I have a lot of empathy towards defenses, the way that people have had to cope with whatever level of trauma and that, um, to honor those coping mechanisms, not try to crash through the gate, but go slow. So, I thought, the more trauma, the more probably, the stronger the coping mechanisms and, you know, just, honor those and again, tap, tap around the edges.

You know, there are plenty of times I felt, what am I doing? Well, I’m showing up, I’m not threatening him, I’m being patient, I’m being kind, I’m being thoughtful, I’m being consistent. So, and I often remind myself when I’m feeling, maybe scared and useless and confused, okay, it’s the process. I don’t have to have any answers, I don’t have to make the great interpretations, um, but I need to do certain things repeatedly and usually it’s [Laughs] works.

They both place an emphasis on her consistency. He says her consistency is reassuring. She says that “showing up and not threatening him” is one of the important

elements of what she has provided. She also discusses her thinking about affect regulation and emotional integration. Interestingly, it can be seen in his interview that her concern about emotional regulation, integration, and complexity is a lesson he learned well. One of his first spontaneous remarks in the interview addresses this. He said, “My first thought when I read about the study was that it was interesting that I’ve been so many years integrating feelings and awareness only to participate in a study that would separate out one particular thing.”

What about pleasure? He goes on to say, “Yeah. It, it’s mixed again, because as, as the awareness grows, as the integration happens, I am becoming aware of what does give me pleasure, but I’m also becoming aware of the lack.” Her consistency has allowed for the expansion both of his emotional awareness and his capacities. Though he dearly values his therapist, he knows that he is not finished with therapy. He tells us he still wants more.

I seem to lack a certain amount of socialization, I lack particular social skills, I lack emotional development in areas that, I guess you could say, I guess, were neglected or not even present, so how could I possibly? I want an intimate relationship with, you know, a lover or a partner and all that would be at the far end of the spectrum of pleasure. And I just talked about going to visit these people, those relationships with people and friends, and how pleasurable it was, but I’m also facing somebody wanting to come visit me and I’m terrified.

So he notes his therapeutic progress. He attributes these changes, as his therapist does to an expansion of emotional capacity, including the capacity for pleasure and to her consistency, which perhaps has provided him with the emotional regulation to allow this expansion. He tells us also that he is not done with therapy. He has aspirations. He can see what is missing in his life. He wants more pleasure; he wants an intimate other. This,

too, may be seen as a therapeutic achievement, given that he spoke of his life before therapy as avoidant of intimacy.

*“I didn’t feel it there.” — The Power of Emotion*

This next clinical pair discusses the power of emotion in their relationship a little bit differently than the preceding pair. They are talking about the range of emotional experience that their relationship engendered. Embedded throughout the discussions is their pleasure in each other, which has been previously noted in Chapter V. It is reiterated here because it is an example of the power of emotional connection. Their pleasure allows for deeper discussion of a range of emotions and their discussion of a range of emotions enhances their pleasure. The patient was nearing the end of his interview, having already spoken at length about the many positive qualities of his psychotherapy, when asked to speak about what in the psychotherapy has helped him. He contrasts this psychotherapy to his former unsuccessful psychotherapy, particularly in terms of the emotional quality of their relatedness.

Janet: Beyond what you’ve already said about what in the therapy you think has helped you to be able to have your voice in the world—to be more exploratory—these things that you’re talking about you have pleasure in now—ways that you didn’t used to have pleasure. Do you have any thoughts about what it is in the therapy that’s helped you in those ways?

6A: [Deep Breath] I get in touch with who I really am. Figuring out what I like, what my hopes are, my dreams.

Janet: How come you think you’ve been able to do that with L.? I think you said you had some other therapists who didn’t work so well.

6A: Nah, because L. actually listens, but she also gives me her input. And she’s compassionate and I can see that. I didn’t have a lot of that growing up. No one actually took the time out to listen and gave time for me, you know, ’cause when I

go there that's, that's my time and that's what, that's for me. And she, she, she helps me feel that, like that. I don't know if what I'm saying is making sense.

Janet: Well, it does, and what I'm wondering about is that you saw some other therapists who made some time for you, right, but it wasn't the same?

6A: No, it wasn't the same at all, because it seemed like they were just doing a job. There was no real feeling going, no real humanizing-humanism or no sense of—I'm all about emotions and all about being human, humans are emotional. And I didn't sense that with those therapists, not at all. Which is odd, because they were women too, all my therapists have always been women, but I didn't feel like that with them, they've just felt like, they were just there to do a job. And, and I didn't connect with them, with that, 'cause, I mean, I wasn't, I wasn't able to talk about what I really needed to talk about, 'cause I didn't feel it there. I just didn't feel it. They didn't really give me any feedback on anything or they didn't really listen that much or I didn't feel like they actually listened to my feelings or really care about, you know, me getting better. I hope I'm making sense.

Janet: You are making sense.

6A: I just didn't feel it and I, as soon as I walked into see my therapist now. Every time I, when I first walked into to see L. it was just like, I knew. 'Cause, I don't know, I just got that vibe [Deep breath] just by the way she, I don't know, I talked a lot about her today, didn't I mean, 'cause I connected with her. It was just like I just knew I was at the right place at the right time and the right moment.

I was tired of feeling so depressed and so angry all the time and self-hatred and very low self-esteem, which I still have somewhat. Still, like I said, still dealing with rage in the fact of, I didn't want to be like that anymore, too overwhelming. And it was keeping me away from people. I am better than when I first saw her, I'm not as angry, far from being as angry or as, as depressed or, or anything. I'm happier than I was when I first came to see L. I was completely broken. She makes me feel comfortable; tells me I can talk about anything I want. And always greets me with a smile; she's compassionate and she lets me be.

The first day I went in there and, just, completely laid everything out on the table. And the reaction I got from her was, like, a reaction I've never experienced from someone feeling my pain. I never knew anybody would cry for me like that. And I saw her crying and I was like, oh, wow. I'm like, I'm sorry. She's like, no, don't be sorry. She's like, you've had a real bad life. And, um, that's why I knew.

He knew that his therapist would be all right because of her compassionate, emotional response. He has continued to find that her emotional expression enhances his emotional expression. They both describe this cycle between them. What follows is the therapist 6B discussing the same phenomena in their relationship. She weaves eloquently between the pleasure in and with each other and their ability, together, to maintain an alliance while discussing painful emotional experience.

You know, it feels fun and enjoyable that we have the range of emotions that we can feel together. That also feels good to me. That, you know, he can cry, and I've cried with him and then we can laugh [Laughs] together, too, and I think it's just having that connection around the range of different kinds of emotion. And then, you know, we talk about how that happens in relationship and that's normal in relationship.

I'm what's pleasurable for him. I'm thinking with the range of emotions that we're able to feel together. I think that feels like a model for him, models for communication or laughter and sadness together. Or anger that you can have a range of emotions with somebody and they're going to accept you, sort of that unconditional, I think it's that unconditional piece, love. And he talks about that, actually. That was something that he didn't get in early childhood. So I think that's happening for him, he's getting that, that nurturance as well. Yeah. And I think he can also have these angry thoughts and rageful thoughts and I don't think different of him for having them, I think that's also pleasure for him. He didn't realize, it felt shameful to him, anger or rage for him. And out of control.

He was, at first it was a little hard to sit with, because hearing about what had happened to him and his losses and sexual abuse, the assault toward him when he was so little. That was really hard. But I think his willingness to heal was also nice for us. I think that's meaningful, part of the joy is that's what we can do together. And I think that has also repaired his hope around, you know, having relationships with people, that he can use our relationship as a model, too.

#### Dissociation: The Problem and Potential of Remembering

*"She's not afraid to remember with me."*

Subject 1A has said about her therapist, "She's not afraid to remember with me. It allows me to remember stuff and see things that have happened and not be afraid." Many

other subjects in the study discussed the importance of them being able to remember traumatic events that were previously dissociated.

This sample is strongly skewed. Many of the patient-subjects in this study had major dissociative disorders. Ten clinical pairs out of the 15 reported that the patient now, or at one time, had multiple personalities. Most other subjects spoke of having dissociated aspects of experience. Though treatment approaches varied, a repetitive theme in treatment was integration of affect, memory, and self states.

The integration of self-states was repeatedly related to integration of affect, both the development of a tolerance for managing painful affect and the expansion of pleasurable affect. Both therapists and patients spoke to the importance of attending to previously warded-off affects and aspects of self.

Here, Subject 15A tells us how this worked in her therapy. She is extremely articulate and names a number of therapeutic techniques that have been useful. What she describes as reparative also exemplifies the therapeutic ground spoken of by many other dissociative subjects. Therapeutic technique and therapeutic action are not easily teased apart. This patient speaks of the use of visualization to help her contain difficult affect. She also discusses the necessity of learning to communicate with other personalities inside and recognizing them as parts of herself. She describes this integration as critical to the restoration of her capacity for pleasure. Embedded in everything she says is the quality of her relationship with her therapist.

Before I started therapy, I was just surviving, is what I was doing. I was probably in my early thirties before I started into therapy. I never was anything beyond just me, this person who was hurting terribly. I mean, I was dying inside and no one noticed, no one. Granted, I didn't walk up to them and say, hey, I'm hurting and I feel horrible, but, uh, I was merely, I just existed. I live on my own, being around people for any great length of time can make me squirrely so, uh... [Laughs]

I guess right now, at this point in my life, having been in therapy for a while, and I'm finally getting a grip on why. I mean, it took a couple of years for me to even eke out the fact that, you know, I just thought I was crazy that there were these other parts. I would find myself not knowing where I am sometimes, especially at work. Sitting in a meeting and all of a sudden I have no idea why I'm here and why I'm, or why these people are talking about things. So, once I finally got that out, things started to, well, you know, they get worse, I suppose [Laughs] before they get better.

One of the things I learned was, I guess it just opened my eyes to everything. Look at the path you've been on [Laughs] and look at what has happened to you and doesn't it, kind of, make sense that you would have branched off, because of what was going on in your life. Once we started communicating with them things started to get better.

She tells us that, historically, she had no one to talk to; she was in pain. She was isolated and she was overwhelmed. Now she is safe with her therapist. Safety is something she emphasizes. Her therapist helps her with internal communication and containment. And she, too, is talking about consistency and reliability. She can remember. Her therapist is available. She can call her when she needs her. She begins with discussing the linkage of therapeutic repair and pleasure.

I just see, feeling pleasure, feeling anything positive was foreign. I think in dealing with, um, finally getting in touch with some of the parts that are inside, that would hammer away at me, and, and, you know, make me miserable, I think, to a certain degree I can feel pleasure. Once we started communicating with them, um, and me realizing that they are me and, and not this separate entity that they feel like, um, I think that let the pressure off of me in terms of always worrying, just always worrying about what I was hearing in my head. [Laughs]

And taking those moments in therapy where we would, you know, just visualize, a lot of that work of, 'cause the overwhelming panic and that kind of thing was very common, and so we would do some visualization and, and just find a way to contain the emotion and not get rid of it.

That helped a lot, knowing that we were just putting it away until there was a time when we could look at it and, and not be horrified by it and all that sort of stuff. Sighs. In general, I mean, I'm not anywhere near as miserable as I was going to work every day, just the everyday grind. I'm starting to see in myself as having little bit of self-worth, a little bit of I'm okay how I am.

Knowing that I could, I always had a sense or walked around with a sense of, I can't talk about this. There's no one to talk to. Having someone now to talk to and knowing that in that room for that period of time, it's safe. That safety feeling has just oozed out of that office and followed me around.

Not all the time, certainly, but that's a change in me. I just have a sense of not always feeling, you know, miserable. I'm not always ready to cry at any given moment."

I guess, just knowing that I've got that and at one point, it seems that when we get closer to, when I get closer to talking about something big something, you know, horrible, that's when I will, you know, I get profoundly upset and I can't shake it off as easily as I'd like to. And knowing, though, that I can call D. [Her therapist.] and talk to her for a few minutes just to put my feet back on the ground and get me through that day, that week. Knowing that the reason my head is spinning and I'm feeling like I'm going to crack in two is because this big, awful, horrible thing is being dealt with.

And, more and more now I feel like my feet are on the ground more and that, although something might be painful, something might be hard, now I kind of believe I'm gonna work through it and I know I will. And it might not happen, you know, I would prefer it all just get taken care of in a day or two and apparently that's not how it works. I've been told time and time again, it's gonna take some time. Um, but where I used to just have no hope of, for anything, anything, I do more so now. And that, in a sense, is a pleasurable thing.

Her previous pain and confusion have not been completely resolved. We don't know beyond her therapist's consistency and reliability exactly what her therapist did that made her feel safe and able to talk about previously warded-off affects and self-states.

We know that feeling safe and able to talk about what once was unbearable has allowed her to feel more hopeful. Now she can consider pleasure. Perhaps because she is no longer so worried or preoccupied with what is wrong with her. Perhaps because of the pleasure she has in the relationship with her therapist. Pleasure had been foreign to her. This subject did have memories of pleasurable experience. She described her difficulties sustaining pleasurable experience. She too is not yet done with therapy, but now she wants an intimate partnership.

I want to have someone and, you know, I'm living my life. I just don't want you to be all alone. I don't necessarily feel all alone. But, for the intimate things, the day-to-day things, the come home and just talk about your day, that I do miss, you know, that I feel like, uh, I'm missing out on the companionship.

So how does her therapist think about what was helpful?

I think that a lot of the whole process has been akin to what happens in the therapeutic process, whether it's a DID client or not in terms of developing trust slowly. Definitely, it was a lot more slowly with her than with clients who are not DID, just having her know that I am not going to judge her for what she tells me. I accept where she's at. I know more so with her than with other clients, because she is so sensitive, to assure her, um. That it's a safe place and that she isn't going to be made to say or do anything in the sessions that she doesn't want to. That, you know, this experience, this relationship, is different from many relationships she's had in the past with people, not that I might, um, hurt, never hurt her but I certainly would not do so intentionally. And that she can know that I am not going to coerce or force or try to control in any way.

She didn't believe that in the beginning, but I think over time she has been able to see that I try to be there. Within she isn't a terribly demanding client but, we meet for a two-hour session every week and generally I will hear from her on the phone once during the week, for a brief conversation. It's often just she will say, I just wanted to touch base. Or sometimes she needs to have a kind of a reality check, get her back on track with her thinking. So she has been able to see that I'm as responsive as I can be to her needs. I think she's been able to see that I keep the limits that we set with the session and with our relationship.

I have done what I said I'd do. And because of that, she has been able to develop a trust. And it is more open now, even if she doesn't immediately follow through on things, which she often doesn't, that I don't criticize or judge her for that or get on her for that but will try to, kinda, brainstorm with her on why something didn't work or why, maybe, she didn't follow through on something. Maybe there is some resistance, maybe one of the alters needs to process that so, I think that it's an experience that is everything the abuse wasn't. It's the exact opposite of what she experienced in her abusive relationship and in some of the relationships with her personal relationships where she's felt betrayed or abandoned.

Her therapist also put a great emphasis on creating a safe, therapeutic relationship.

She tells us that she thinks some of what creates safety is a reliable environment free of

judgment. She also discusses the importance of her being responsive to her patient.

Embedded in this description is also the idea that the patient “is not terribly demanding.”

The therapist does not find her particularly difficult; being responsive is relatively easy.

This client engenders responsiveness in her therapist. While both patient and therapist

emphasize a safe environment that potentiates discussion of anything, even that which

was previously unspeakable, the therapist indicates that this has evolved mutually. The

patient had not only been told that the therapist was safe, she had to experience the

therapist as safe and the therapist needed perhaps to experience the patient as not being

overwhelming. In this milieu, the patient felt freer to know herself and remember her own

experience. The complexity of arriving at this goodness of fit may be illustrated by the

following comments of the therapist. Here she talks about the patient’s previous

psychotherapy.

There’s a lot of that because in addition to personal relationships, she did feel very abandoned by her previous therapist. So there, not only were there abandonment issues in her personal life, but with, um, her previous therapist that, kind of, added to that fear. So I’ve told her that I don’t plan to retire soon.

I’m honest with her about the limits of what I can provide for her and so I’m hoping she respects that and, I mean, she seems to respect it and honors that and understands that. And, it seems that the previous therapist, and I guess therapists have different approaches about that, would not disclose any, any information about her personal life, nothing. And, I don’t know if she was concerned about the client overstepping her boundaries, but I don’t think she’s like that. I mean, if I’m gonna be off taking vacation time, I prepare her for that, but I will tell her where, I mean, I won’t tell her exactly where I’m staying, but I’ll say I’m going to Wisconsin or whatever. And I think she appreciates that. It’s almost as if, I think, with her previous therapist she viewed her, she thought she was some kind of a maniac or crazy person. You know, why wouldn’t she say anything about anything? I can’t answer that question. So, I tell her, you know, therapists have different ways of viewing that, the whole boundary thing.

Both the therapist and her patient spoke to me about her previous therapist. Though the therapist seems hesitant to judge the previous therapist, she indicates that the former therapist was overly rigid about boundaries with this patient. They both implied that the previous therapist had not been responsive. She had been reactive, leaving the patient feeling unsafe and ashamed of her needs. The patient had not felt free to remember. She felt dysregulated, unable to explore those different aspects of herself that she has now become able to know in her current therapy.

#### “It’s the Relationship”

Over and over again, patients and therapists tried to put language to their experience of the therapeutic relationship as elixir of healing. We have already discussed safety and trust, reliability and consistency, affect regulation and emotional integration, and still these terms do not seem to convey the rich complexity of what the subjects meant. “After approximately a half century of psychotherapy research, one of the most consistent findings is that the quality of the therapeutic alliance is the most robust predictor of treatment success” (Safran & Muran, 2000, p. 1). These findings concur. Could pleasure be a necessary component of a therapeutic alliance?

There is a multitude of ways that these clinical pairs discussed the quality of their relationships, which can be understood as components of the therapeutic alliance. Here is one therapist offering her understanding. She starts with a statement encompassing all the previously mentioned component parts and goes on to more fully elaborate her understanding. Notice again the embedded discussion of the therapist 13B’s own pleasure.

I provide a safe and secure relationship so that she can count on me to be there for her as she learns to self-regulate and begin to explore her world in new and more productive ways. I enjoy working with her like a parent enjoys watching and supporting their child develop and grow through good times and bad. There are several ways our therapeutic relationship has helped her make improvements in her life. I believe our relationship has allowed her to be open to other female relationships and relationships in general.

She was isolated in the beginning of treatment or would become involved in relationships that weren't good for her. She now has a good friend who she depends on for support and who she can support. Because of the trust she has in our relationship, she is able to take chances and begin to build trust in other relationships. She has also had a couple of relationships that have been somewhat positive, although understandably because of the abuse, she still has difficulty trusting in these relationships.

She has begun to learn to express some of her feelings in relationships. She has gotten angry at me and has been able to express herself without anything horrible happening to her. She is sometimes able to express her feelings in her friendship, which is directly related to her being able to do this in our relationship. She is able to become angry and disappointed and continue to sustain a relationship. In the past, if a friend disappointed or injured her, she would cut them out of her life.

Our relationship helps calm her and helps her to self-regulate. She has expressed many times that when she is anxious or panicked, she repeats calming thoughts that I've told her or she has experienced in our relationship. She hears my voice and is able to calm herself. She monitors herself to see if she can calm herself or if she needs to call me. She rarely calls, but talks about her experience in our next session and how she has used our relationship to help her regulate. Our relationship has allowed her and some of her parts to begin healing.

She is in relationship with someone who listens and takes her and her reports of abuse seriously for probably the first time in her life. She and many of her parts experienced people, who were supposed to be "helpers," betray her. She is learning to trust in a relationship. I believe she and I have a bond with each other, a strong attachment. I am attuned to her and we experience an affective resonance. Most of the time I understand her and I am empathic. She feels this.

### *Attachment*

In addition to specifying some of the nuances in their relationship, which are differentiated by the therapist from her patient's previously abusive relationships, she names a component of relationship not previously cited in this study, attachment. Patient-subjects in this study never use this word to describe their relationships. Considering that the word "self," discussed in the next chapter, was used about 400 times in these interviews, the relative scarcity of explicit discussion of attachment is interesting. Perhaps it is too formal, reeking of remote theoretical language. Still, the same search showed that fully 10 of the 15 therapists never uttered the word attachment, either.

Attachment is clearly an implicit topic in these interviews. Many subjects previously quoted talked about "connection." What follows is a sampling of those therapists who did talk explicitly about attachment.

Subject 3B talks about the complexity of the problem with a patient who has been extremely maltreated and frequently betrayed in relationship. She believes that closeness or attachment does not necessarily or completely relieve her patient's anxiety. In fact, she portrays the attachment as both important and problematic. She is also revisiting the problem with pleasure, that is, how and why her patient interrupts her pleasure.

3B: She has some awareness of feeling pleasure that she interrupts.

Janet: Is that something that she knew about before she came into therapy or that developed over the course of therapy?

3B: That's developed.

Janet: Can you tell me a little bit about how you got to that awareness, how it developed over time?

3B: I think I've always been there and I continually drop seeds of comments and she responds more and more over time when something feels good or at least stops feeling bad. Do you allow yourself ever to have peace? Or is feeling good a bad thing? Is pleasure, sensual pleasure, is that in itself an innocent biological thing or is that something means snotty and dirty and evil?

So we're in that process. I've always thought about these things. In terms of the nature of, I've seen plenty of people that would begrudge someone a moment's peace or to feel good about themselves. I've seen both sides of it. So I, I think I've just been immersed in this professionally just, or as a human my whole life. I noticed pretty quickly that the word okay, good, or fine, was not in her vocabulary. If asked how are you today, most people will say the cursory fine or okay.

Never for her. So that was noticeable right away; it's still like that. She's always so anxious and it permeates the room and I comment on it. In fact, she has one peaceful surround in which she feels relatively safe. If I ever named that to her, she'd find a way to undo it because she'd realize that it made her feel safe. And if there were consciousness, I think she'd sabotage it. She's still in that place. I'm careful to not comment positively overly much, because I think that makes her anxious. I'll do a little and then if I see any whisper or unease I lean back, but gradually I see a very slow growing tolerance to a word of praise or, um, eye contact and a smile.

I think, as she and I have fostered our attachment, she's also more anxious and dissociative about being here, because she's growing more aware of the comfortable thing we have and there are times that, in itself, scares her and she needs to put up a wedge. Once she tunes to me, I fade out. Um, sometimes I'm sure it's my therapeutic screw ups, but sometimes I think it's because she feels warm feelings and she doesn't know where to put that.

Therapist 3B clearly thinks that the developing attachment is therapeutically helpful, though problematic. The following therapist sees the attachment as therapeutically critical and not particularly problematic. He freely expresses the depth of his own attachment to his patient.

14B: Well, I think she's processed a lot of these memories so that they're no longer have to be dissociated; they're part of her history now and I know her attachment to me is probably the most important thing there. She feels safe with me and we do laugh. We laugh at lots of things. We probably share many values and a view of the world and she deals with difficult people in her work. She comes in and talks about that the way you might talk with a client who's not a

trauma client or you think somebody's whose just dealing with normal life demands and stresses and what not. I don't know if I'm answering your question there.

Janet: Well, you, I think you said, "I think her attachment to me is perhaps the most important thing there." So, I'm wondering if you could talk some more about that, what do you think about that, how come you think it's, maybe, the most important thing, how did that develop between you, the two of you?

14B: Well, part of that's the way I think theoretically that's important. How did that develop? I've been reliably there for her. I'm very devoted to her. I love her. I would do whatever it takes to help her. I would see her without pay, if that's what it came to. I think she knows, even though she certainly insists on paying. And we keep the professional boundaries.

When she was a mess early on, I held her at times when she was, just, crying, sobbing uncontrollably. The moment she would start to feel uncomfortable that some man was touching her, I would just back away and give her the space.

I do hug her at the end of the sessions, but there's never been any sexual tension. I don't think there's even been any sexual imagery or anything like that between us. I mean, it's stayed very clean and easy for me. I mean, there's some patients that I could never do that with, but that's not been an issue with her. Maybe because I saw her as such a child from the beginning and, and saw her pain so clearly, so I know I've been a good attachment object for her. And I know that she feels that I'm the one person in the world that she can come in and be a child, be an angry person, just be that. So, I mean, I think of her like one of my kids in, in that sense that whatever they need I'm going to do whatever I can to provide it.

Finally this therapist talks about some of the changes she has seen in her patient over the course of therapy and how she thinks these changes are related to acceptance and attachment. She, like the previous therapist, also talks about her love for her patient.

6B. I think he's beginning to care more about himself and like himself more. So his self-esteem is increased. And I think his self-worth as well, although that's a struggle, but I think it has been enhanced, through our work. He is able to actually verbalize things he likes about himself.

Janet: What in the therapy do you think has helped him, if anything, become more able to do that?

6B: So much that goes on, I'm trying to speak to it. I really just think it's the acceptance. And the genuine regard for each other. I think that's just something that's, the energy is positive, but I think it is the loving feelings, too. That and the unconditional regard for him allows that to happen, allows him to have room for it to happen. He needs the attachment between us, I guess—carries him and allows, and allows things to happen. I guess the space for it to happen, that would make sense, of what he didn't get, you know, an attachment to his mother. I believe that's a big piece of it. We've talked about, too, some maternal transference going on and that he feels nurtured and cared for and it matters to me whether or not he shows up.

Theoretical language, however popular, and everyday word usage are distinct.

The aforementioned transcripts are not the only place in the interviews in which subjects are discussing attachment. These are the only interviews in which subjects used the word attachment.

As already quoted throughout these findings, subjects use the word connection over and over again. They speak about the quality of the relationship. Patients speak about how safe they feel with their therapists, how secure. They speak with pleasure about these aspects of the therapeutic relationship and they speak about how these aspects of the relationship are pleasurable and enhance their ability to find and experience pleasure elsewhere in their lives.

## CHAPTER IX

## FINDING A SELF

One subject had this profoundly elegant exchange with me about his relationship with his therapist.

10A: That's what made me happy, made me very happy. [Looking very serious.]

[Long pause]

I didn't have to be somebody else.

[Long pause.]

So, I got to bring that sense of self, have it affirmed by this person I was with, yeah, that was nice.

Janet: You're abruptly smiling. [Smiling]

10A: Yeah. [Beaming]

He embodies his pleasure as he speaks. This subject was thoughtful and articulate throughout his interview. He had spoken somberly of his childhood and the ongoing destruction of his pleasure. He was an intelligent and curious subject who felt grateful to his therapist, but his emotional expression was continuously restrained. He told a complex and detailed story about the revival of his capacity for pleasure. Only when he began to speak of the revival of his self, did his pleasure come alive in the room.

This chapter addresses the subjects' discussion of finding a self. It is interesting to note that the researcher made no conscious attempt to facilitate a conversation about the

development of self across the life of these therapies. Subjects were never asked if they experienced a change in their identity over time. They were not asked about their capacities for self-soothing or affect regulation. They were not asked about whether or not they felt they could initiate or pursue interests of their own.

These topics arose spontaneously in the context of talking about pleasure and the problems they had experiencing pleasure. Discussing pleasure, for these subjects, was so intricately interwoven with the fabric of identity that the importance to them of finding a self emerged over and over again in the interviews. Upon doing a word search, the researcher was astonished to find in the interview transcripts that subjects had used the word self approximately 400 times.

This chapter enumerates the various steps along the way to finding a self. We begin with a discussion of patients' histories. They speak to their experience of having others interfere with finding themselves. The subjects then go on to describe the importance to them of finding a self. They discuss seeing "glimmers" of who they might become. As they move towards describing the journey, the hard work of finding a self, they keep returning to the topic of pleasure. They tell us again and again that pleasure requires a self. Without a self, pleasure is like a suit of clothes without a body, all dressed up with no way to go.

### Interference with Finding a Self

These subjects did not speak primarily about neglect. Their concerns were not with an absence of attention. They spoke about destruction, active destruction of the self.

Okay, um, pleasure in my life, well it's very hard to talk about that. It would be easier to talk about pain and misery. Yeah, because it's so, so scattered and so, um, I think I should tell you that my, uh, dad was a monster. So, my trauma is what he did to me, started from my earliest possible memory. Uh, because then I realize the total destructiveness of what happened to me. I can't pretty well deny it. I can, I don't have to think about it. Then I can be like a normal person.

But when, you say, tell me about fun, I realize it's the things I enjoy doing. I play the organ out of this old church in this town because after I do it, I get so involved in doing it. That it's, sort of, like I am like in a tuna fish can and I'm all jammed in there and every once in a while I get a knife that pries me out. It's so terribly frightening 'cause I'm not, I, it's just terrifying. I can then be; enjoy going out to dinner. I can go out to dinner and I cannot think about the trauma. Otherwise, it's just always, always, always there. [Blows nose] And, and it's a secret, 'cause I can't tell anybody. And, and if I say one thing, but I, I just absolutely cannot talk about it. There is no one who wants to hear and it's essentially the basis of who I am.

In general, people like me 'cause I do all this stuff for them. I've got all these compartments in my head that are sometimes talking to each other and sometimes not. I can do charts and graphs, and that's probably been my, my greatest enjoyment is to have a project and to finish it, even though the project is extremely painful.

I don't even enjoy when the reward comes. [Blows nose] And they say, oh, you get the whatever you get. I'm glad 'cause I don't have to do it again but there's no joy. I cannot, I don't think I've ever experienced joy. And, and maybe I'm, I'm lying, uh, but I don't think so, I'd have no reason to. I haven't, *I think before a person can have pleasure, a person must have a self. You must be able to say, I want to do this. And then do it and nothing bad happens.* [Italics added.]

This subject, like others interviewed, makes the argument that having a self precedes having pleasure. She is clear that one must be safe, to know that “nothing bad happens,” before one can begin to reckon with desire. The definition of self she has given

us is embedded in defining, reaching for what one wants; pleasure, for her, is inherent to this act of defining a self.

Subject 4A is saying something very similar here. She feared that the expression of pleasure would signal her abuser that she has a separate self. She tells us about both the development and maintenance of her hypervigilance. Relative safety was obtained by not exhibiting a self.

I guess I am having trouble not being able to recognize that I'm not in that dangerous situation anymore. And so there's no need to continue with that sticking to the family system inside in the same way, guiding them in the same way because there's not, there aren't the same risks as there were before. So, I think that the main part that has been a problem with allowing me to know. And, to have any kind of just, joy, pleasure, it's just too risky. Yeah, and not paying attention and also the, *the fact that any kind of pleasure for myself, having a self was trick.* [Italics added.] If I had a self separate from the abuser that, on any level, was a problem.

I mean, I had to, I kind of mastered really, during the time of abuse and trauma, I mastered, in a lot of ways, as much as was possible, what to do to try to avoid the trauma. One of many things that triggered it, *having a self separate from the abuser.* Having any kind of joy or pleasure separate from that individual. It was presented and it triggered the abuse. I think that that's played a huge role."

### Searching for a Self

Whatever was or was not allowed in the lives of these subjects, they were able to articulate longings. They wanted and actively sought themselves. Perhaps this partially explains why these people, who were so injured in relationship, still persisted in seeking a psychotherapeutic relationship. With little reason to trust intimate engagement, all of these subjects pursued a therapeutic relationship despite numerous previous relational failures, including those with former therapists. Here, this subject tells us how she has felt misunderstood by our profession and what she wants.

I just think that Maslow's Hierarchy, pleasure, oh my gosh, I'm down here worrying about, can I sit through work without falling apart? Can I get through today without cutting myself? Can I, will I have enough energy to walk to the dog? Just, I'm at a, a really basic crawling around level and [Laughs] and I'd like to get beyond it. But I think that, for me, not having killed myself is just remarkable! And I'm able to be a competent person and I think that's a pretty good accomplishment. And I guess pleasure is related to survival. I'll give you an example. Yesterday I was so incredibly depressed. I just thought, I just can't live anymore. This is it. I'm gonna kill myself today. I was laying there and thinking, all right, here's what I'll do; I'll kill myself November 16th, because that will be the 11<sup>th</sup> anniversary. And that cheered me up so much that I was able to get up and function and do stuff, 'cause I thought, I don't have to put up with this any longer than 3 weeks. I look on the calendar, I saw what I was doing on, on November 16<sup>th</sup>, and that seems fine. So the pleasure kept me alive for a little while longer.

I don't think that any of the theories or any of the books I've read, like stage four reorganization, I don't think that's it for somebody like me. I think it's redemption and I think it's about survival. I don't think it's about finding meaning or being a better person from it, necessarily. Beyond survival, I think it's just putting a person together, just finding out, being able to walk into the grocery store and say, what do I want? [Laughs] That would be so wonderful! To go to a restaurant and not order what the person, the other person with me is having! [Laughs] To have a personality, [Laughs] that would be so great, or, or to recognize the one I have, you know, to have one. [Laughs] That's all I want to say.

She says a great deal. A smidgen of pleasure and the possibility of hope keep her alive some days. And she has a vision. She has a vision of what would be really wonderful. She pictures herself saying what she wants. This seemingly simple act would be a great accomplishment. She is describing the moment she is striving towards as knowing she has a self.

### “No Place to Put It”

This next subject describes the importance of other people in finding a self. She talks about needing “validators.” Without safe, engaged others, she found she could not know her own experience. Even in the presence of the “validators,” she had to repeatedly check her experience against theirs to be able to feel what she felt. The ongoing disruption of pleasure with violence in her family of origin had splintered herself. She was left with “no place to put joy or happiness.”

When something good happened, I would have to have a validator. I would want to take a friend with me if I was going on a trip or something, to be able to validate that I had a good time. I had to talk to them later. I had to share that with someone else, because it's almost like I couldn't trust me with it or it would go away. It felt like it was too overwhelming, the sensation, too unique and too fleeting. It would be difficult for me to take in. I needed time to process that all, and having a friend with me to know I was having a good time.

This subject wrote me after the interview to further elaborate.

We were not sure how accurate we were Monday. See, pain is pain. Hope is pain and happiness is often pain, too. We still need validators. Pain and joy were taught in a mixed-up style. The pain maestro, my dad, spent more time being an angry person whom I experienced as the nearest thing to God. There was lots of fear.

Even when the father monster tried, for the last 2 years of his life, to get help, I could feel nothing when he died. Maybe a little joy. We could reason that if he was dead, maybe someone could come and find us and love us, me. Somebody would be able to see through the Cosby family charade and know what our family was really like.

We had no place to put joy or happiness, because it was so unpredictable and often turned ugly and terrifying. With B.'s [her therapist] help, we are looking for our self. We are integrating. We are looking for a place to put joy and trying to accept it, even when we fear that something awful will happen.

The often-frantic management of persistent, overwhelming pain left this subject in pieces. She speaks to her fragmentation and dissociation throughout the interview. Diagnostically, we speak of a dissociated self of multiple identities. Interestingly, she speaks more about being without a self. She has no container for her experience. She borrows others, when she can, to hold her pleasure, her good experience, but she tells us she has had no place inside to put that experience, no self of her own.

### “Glimmers”

Awareness that leads to change is not described by these subjects as satori. They do not describe moments of enlightenment. They never mentioned a stunning interpretation made by their therapists. They do describe an incremental process of mutual dedicated hard work. Often, this hard work has been going on all their lives. They have been striving. In this next vignette, the patient describes the flickering of awareness of her own pleasure and the possible elaboration of herself she has been glimpsing throughout her life. She is still a work in progress, but now she has more “glimmers.”

Yeah I mean it, I think all throughout my life, like I have glimmers of what could be. That's the thing that I think, it's never pure dread, pure fear. I mean, I have glimmers of this joy, just for me, inside of me and only for me. That it's for milliseconds I can feel that. And I feel that it's okay, just for milliseconds. And I remember that there were certain aspects of those kinds of things that I enjoyed as well. So, there, I wasn't constantly censoring myself, constantly analyzing my every move. There were, just, the glimmers of me. If I were to do this all by myself, without my mother there, I could derive pleasure from it. It would just, sort of, fade in and out. You know, sort of like dappled sunlight kind of thing. Then I still have the same experiences today, where I know, I could feel what is possible and that's what makes me continue to work so hard in therapy. 'Cause I know that I can, and I feel strong that I can get there some day. It's just a long road, that's all. I've recognized it as being a core of what I, what I'm trying to seek, um, through this type of therapy.

## Empowerment

The depletion of self that many of these subjects described included a restraint upon both their own initiative and their difficulty feeling entitled to set boundaries with others. Both of these problems have been presented in previous research on trauma survivors (Koenig, Doll, O’Leary, & Pequegnat, 2004). The latter is often discussed as problems with the right of refusal. Feeling able to know what one wants and what one doesn’t want was often a burgeoning capacity for these subjects. Having a sense of agency, the felt ability to act upon interests and preferences, empowered these subjects to make changes in how they lived in relationships. This subject discusses how these changes in herself gave rise to new forms of relationship and recognition.

I think back on when I would walk into the management’s office and they would talk to me and I would just burst into tears. So B. [Her therapist] and I would practice other ways to be, or talk about other possibilities. You know, she would ask me about what do you think are some other ways you could or would like to deal with it? And I started using them, including telling him that I did not appreciate the tone when he spoke to me. I said, I was going to be respectful when I spoke to him and I expected the same kind of treatment, even if it was not good news.

[Laughs] And when an issue did arise in the building that involved several people—but it did not involve me—I was called down there. I made an appointment with my manager and I came back and I let him know that I didn’t need to be there and I did not appreciate the denigrating talk about gossip aimed at me. I said I’m not a party to that. I didn’t have anything to do with the situation.

But, mostly, I was able to defend myself and that felt good and so the relationship with my manager has changed. And he talks to me very differently. He’s probably gotten feedback from other people, too. [Laughs] So that, that gives me not only joy, but it makes me feel empowered.

Now there’s a banquet coming up. That will be honoring the people who work in volunteer. I’m one of two people being honored for my work. And I was asked by my coordinator to give a speech, since that used to be a very uncomfortable thing for me to do. I don’t know why, it doesn’t click with the rest of my [Laughs] life, but I’m comfortable doing that now. And to get an award

was, I, kind of, like I had that child-like, kind of, wonderful feeling, like the teacher's gonna put my name, my picture on the board!

Her delight is apparent. She has told me a very abbreviated, but compelling narrative of how she became someone who has done work that others want to recognize. How her standing up for herself, how being able to insist that she be treated with dignity and respect, led her to this moment of recognition. Now, not only is she a person who can say "no," she is a person who can say "yes." She can look forward to giving a speech with confidence in her own voice.

#### Affect Attunement

Many subjects discussed the quality of the emotional connection with their therapists. The therapists also talked extensively about their pleasure in connection with their patients. This has already been discussed in chapter four, *The Disrupted Story*. I add this vignette here because this subject is describing vividly not only the depth of the initial emotional connection with his therapist, but how that emotional connection has resonated throughout their therapy. It is her affect attunement that makes the therapy possible. He has been able to be and become more himself in her presence because her affective response has engaged his trust. Clearly, he has developed a deeply needed idealization of her, which is beginning to support his further explorations.

When I first met her, my first day I went in there and just completely laid everything out on the table. And the reaction I got from her was a reaction I've never experienced from someone feeling my pain. I never knew anybody who would cry for me like that. And I saw her crying and I was like, oh, wow. I'm sorry. She's like, no, don't be sorry. You've had a real bad life. And that's why I knew. She has listened to me other times since then. I told her things that I've never told anybody in my life, never. I just, I still do, somewhat, but I look at my therapist. I'm sorry, and, I, like she can't do no wrong, 'cause she never stirred me

any wrong at all. And, I look at her and, like, she's perfect. And she tries to tell me, I'm not, I'm human, too, women aren't that perfect, either. And 'cause she tries to get me different outlets then with just her to broaden my support group. And that's what I mean, like, trying to push me a little bit to reach out to other outlets and all that. She wants me to be able to be more in the world.

### Identity and Pride

It has been argued that the development of a healthy sense of self requires having an identity, both knowing who one is and feeling some pride in that person. These subjects speak to emergence of identity and pride. Their pleasure in this evolution is embedded in both what they say and how they say it. Listen to the emotional cadence of what they are saying.

Subject 15A says, "I'm allowing myself to be a little more gentle. This has allowed me to, huh, get some sleep, honestly, and not be so hard on myself, you know. Now I can, kinda, joke along with people." [Laughs] Smiling broadly, she says, "You know, of course, in the office I'm on the emergency response team. They kid me about the whole thing. And now I just smile and say. Yes I am. And you, you won't be making fun of me when you're out of the building safely! [Laughs] And there's a, you're all laughing, but you'll all be singing a different tune then."

She is delighted, now, in owning her intelligence, her skills. She contrasts this story to her description of herself showing up shoddily dressed for her own college graduation. She has no pride in herself then. Now she relishes her capacities.

Subject 2A talks about the development of her identity within the last few years of psychotherapy. She started therapy while in an abusive relationship.

But I've been, it's been pretty much exactly three years since I broke up with him. I've been trying to find myself again. [Smiles] 'Cause I haven't really remembered things that I think or do. Even if I do have, like, a moment where I, like, laugh to myself where I think of something funny or that I want to know about, I have trouble remembering it for myself.

I remember every little thing that everybody else says, but I don't remember what I say. It's really, it's really bizarre. It's really hard for me to, because it's like, that's the thing that always made me the most stressed out in classes and things like that, is that my mind would go blank. Just like, I would have to write it down first. I was always thankful if I had a teacher who was like, think about this, write it down, okay, now, and then I would read it and I would be fine. So I've been working on trying to figure out how to be present to myself [Big smile], because I am really, really bad at that and it's not because I mean to disregard myself. In some way, it's just, it's something that has got me in trouble I guess growing up is being present to myself.

So she is beginning to learn to be present to herself, to remember who she is, as well as others. She has had no problem remembering others. As she spoke, she smiled. She is clear that her problem is not yet solved. Still, there is pleasure in this beginning. She has inklings of who she is that she can retain.

Here, another subject talks about her search for identity. She tells us that this was the most important part of her therapy. She says, as so much of these subjects reiterate, pleasure would not have been possible without finding her self. Subject 5A says during the interview, "I've had to really find things. I had to find things to identify myself. To make them mine, or say, this is me, this is what I like and before therapy with R. I didn't know."

Later, she wrote to expand upon what she had said in the interview.

I didn't feel that I was clear how R. helped me experience pleasure. I had mentioned to you that she helped save my life. I want to break that down for you so that it is a bit more clear.

First, she helped me learn how to be alone with myself so that I was comfortable in my own skin. Before learning how to do that, I ran, ran, ran—from

the simple things, like not going home until it was time to go to sleep, and that was years. I couldn't sleep, so I'd continue running.

The biggest thing was finding my own identity. I know that when I first started seeing her, I didn't have one. And to be honest, I wasn't sure I wanted one or even knew what one was!

This was a very slow process that was really the dance. I'd take one step forward and four steps backwards. Slowly and eventually, I'd start naming goals. Like owning a home, finishing school, getting a career. I needed to see her. I don't know if it is this way for people who don't ever get abused, but I know that for me, the material and tangible things helped form my sense of identity. I don't know if I would have felt a sense of pleasure without those things.

I thought I'd share with you some of the things I have pleasure in today. My home is one thing; I especially enjoy decorating it, particularly the outside, gardening, so I have a summer retreat. I also have five little dogs I love tremendously. I also take great pleasure in thunderstorms. Perhaps it is always because the thunder sounds like something remembering itself.

She has perhaps remembered herself. In remembering, she has gone to school, found a career, fallen in love, bought a house, and made a garden sanctuary for her new family, her pack. These make a stunning list of therapeutic gains.

She spills over with delight in this, her own life that she has made. She is eager to tell me the details of what she has achieved. We can speculate about her pleasure in material things. Her single mother's poverty was often connected in her narrative with the vulnerability she experienced to injury. Maybe economic security and material goods resonant more for her as safety and freedom from exploitation. This is speculative. What she tells us is that finding her identity is how she found her pleasure. Having an identity, a self, made pleasure possible.

I will leave the final word on this topic to subject 12A. Her therapist described her as the most suicidal person she had ever worked with in a practice that counseled many trauma survivors over thirty years. The patient-subject also talked about the depth of her

previous depression and the many near misses over the years when she felt that her therapist had saved her life. She told me that she was miserable all the time for many years and just wanted to die.

At the time of this interview, she had finished therapy. She had a home and a career. She had good friends, neighbors, and cats. Her creativity had blossomed and she had published several pieces of her writing. She intended to write more. She laughed long and loud throughout the interview. I laughed, too. She told me how she had made a study of humor. She had wanted to learn how to help people laugh. She had taught herself well.

This is what she said she got out of therapy: “You talk about pleasure. I’ve just never thought about it. But now there’s the stuff I like to do and I really enjoy doing it. I enjoy doing stuff more now than I did before. It’s like, well, it’s like a total transformation between, um, who I was and who I am now.”

## CHAPTER X

### FINDINGS AND IMPLICATIONS

#### Introduction

This chapter will discuss the theoretical and clinical implications of the study. A series of interviews were conducted from which to examine possible understandings of the following primary question: What is the role of psychotherapy in restoring or enhancing the capacity for pleasure in adult patients with reported histories of chronic childhood abuse and/or neglect?

The findings reflect how the patients and therapists interviewed defined pleasure and its relative importance in their therapeutic process. This is an exploratory study with a small non-random sample. Findings were evaluated to understand their meanings for both the individual subjects and the group of subjects. There are no statistically valid or reliable findings. No hypotheses were proposed. These subjects narrated their experience of pleasure and how it impacted their psychotherapy.

#### *Summary of the Findings*

1. All patient-subjects reported the capacity to experience pleasure throughout life prior to therapy.
2. Subjects defined pleasure as a variety of positive affects in two primary categories, pleasure in activities and interests and pleasure in relationship.

3. All patient-subjects reported a history of traumatic disruption of pleasure in childhood.
4. Some patient-subjects reported a history of internalizing and reenacting their own disruption of pleasure.
5. Narratives of the patient-subjects were consistent with the narratives told by their therapists.
6. For some clinical pairs, both parties spoke positively of an important therapeutic event when the therapist stepped out of his or her usual treatment frame.
7. Safety, consistency, reliability, predictability, and compassionate caring were spoken of throughout the sample as elements that created a pleasurable and therapeutically reparative relationship.
8. Patient-subjects spoke repeatedly of the importance of finding a self to the experience of pleasure. Pleasure enhanced their ability to find a self, and finding a self enhanced their capacity for pleasure.

#### *Narrative Research*

According to narrative methodology, findings can be evaluated for narrative validity, not historical truth, based upon coherence and correspondence of source materials (Riessman, 2008). Correspondence evaluates the question, “Does the reported sequence of events in a personal narrative match accounts from other sources?” (Riessman, 2008, p. 187). In this study, correspondence was high between both members of each clinical pair. Correspondence was also high across the group of patient-subjects, across the group of therapist-subjects and across both groups.

As we examine the findings theoretically, we are cognizant that the theories chosen for review are neither correct nor exhaustive. These theories give us a lens for making meaning of the data. Other theories not applied here would give us other perspectives. Findings are compared to the literature to determine areas of agreement, disagreement, and potential advances in theory.

#### Theoretical Formulations About the Nature of Pleasure: Chapters IV and V

##### *Findings*

“Chapter IV: Introduction to the Study” and “Chapter V: The Disrupted Story” discussed the variety of ways that psychotherapy patients who were subjects in this study articulated a narrative describing the disruption of pleasure in their lives. Pleasure was reported as a pre-existing capacity experienced throughout life. The story of the disruption of pleasure is told both by the patients themselves and by their therapists. First discussed is how therapists and patients defined pleasure. All patient-subjects reported having some pleasure throughout their lives. The discussion that follows illuminates the variety of external interruptions and assaults upon pleasure that this population experienced. The chapter ends with a discussion of the internalized patterns of disruption that the subjects elaborated upon.

##### *Implications*

There are three implications embedded in this chapter’s findings.

1. The implication is that given the extreme childhood circumstances of abuse and neglect in this population, the capacity for pleasure may be a resilient capacity.

2. The implication of this study is that definitions of pleasure were both complex and multi-faceted. Two major categories were delineated. Pleasure that derived from the idiosyncratic organization of the self, sensory pleasure, and interests were often discussed. Pleasure in and with others in relationship was an even more predominant theme.
3. The implication of this finding is that when historically safe relationships were not available, pleasure seeking did not cease, but was disrupted.

#### *Implication #1*

Pleasure was reported as a pre-existing capacity experienced throughout life. Given the extreme childhood circumstances of abuse and neglect in this population, the implication is that the capacity for pleasure may be a resilient capacity.

This is worth further investigation. These findings posit the question of whether the capacity for pleasure itself is a resilient feature of human neurobiology. Resiliency may offer an explanation for the genetic expression of a genetic endowment.

#### *Resiliency*

In resiliency research literature, pleasure has been little investigated or thought of minor importance.<sup>1</sup> The study of protective factors that lead to resiliency has been of interest to researchers, theorists, and clinicians. This capacity has been seen as consisting of a natural invulnerability (Anthony & Cohler, 1987), which may emerge from a variety of protective factors (Rutter, 1987; Davidson, Hahar, Lawless, Sells, & Tondora, 2006). These factors have been categorized as a triad constructed of *social resources* (Mrazek & Mrazek, 1987; Long & Valliant, 1989, O'Connell-Higgins, 1994; Schumm, Briggs-

Phillips, & Hobfoll, 2006), *familial attributes* (Wyman, Cowen, Work, & Parker, 1991; Demos, 1989; and O'Connell-Higgins, 1994), and *individual psychological strengths* (Mrazek & Mrazek, 1987; Rutter, 1987; Demos, 1989; O'Connell-Higgins, 1994; Cicchetti & Cohen, 1995). Pleasure may be categorized as a possible *individual strength*.

In Viktor Frankel's post-holocaust account of survivorship in *Man's Search for Meaning* (Frankel, 1959), he said, "Yes a man can get used to anything, but do not ask us how" (Frankel, 1959, p. 30). Having made this statement, he goes on to discuss many factors that sustain those in dire circumstances, including, hope, curiosity, compassion, human connection and identification, religious practice and spiritual belief, remembrance of ordinary positive experience, heightened attachment to beauty and art, the capacity for humor, the ability to find great joy in trifles, and small reprieves.

Frankel (1959) is talking about positive affective experience. There is a body of research accumulating investigating the impact and import of positive emotion on physical health and psychological well being. Tugade, Fredrickson and Barrett (2004, p. 1162) state that their "findings support the idea that positive emotions play a critical role in contributing to psychological and physical well being." Others have noted that the overall disruption of equilibrium prevents many trauma survivors from experiencing any consistent sense of well-being (Briere, 1996; Chu, 1998; Herman, 1992; Putnam, 1997).

"Psychological resilience is defined by flexibility in response to changing situational demands and the ability to bounce back from negative emotional experience," (Tugade, Fredrickson, & Barrett, 2004, p. 1168). Others have noted that resilient individuals are not only capable of cultivating their own positive emotions, but

additionally are able to elicit positive emotions in close others, caretakers, and companions (Demos, 1989; Kumpfer, 1999; Werner & Smith, 1992).

In their second study (Tugade, Fredrickson, & Barrett 2004), the researchers investigated positive emotional granularity, the individual differences in how individuals use positive emotion words to represent emotional experience. Using the emotional sampling method which Csikszentmihalyi (1990) also used in his studies, they found that individuals who were more able to label positive emotions with greater precision, those with high positive emotional granularity, were associated with a more engaged and proactive coping style.

Emotional sampling techniques randomly ask individuals to report what they are feeling to achieve a baseline of individual emotional experience. Tugade, Fredrickson, and Barrett (2004) then correlated this data to physiological stress indicators to evaluate the relationship between positive affects and coping. They found that positive affect, especially the ability to specifically express positive affective experience, enhances coping with stressors.

Beyond genetic endowment, poverty, and racism (Putnam, 1997), familial characteristics (Demos, 1989), health, educational, social welfare, and community resources (Mrazek & Mrazek, 1987), all the aforementioned authors are emphasizing the critical importance of individual capacities. Pleasure itself has not been investigated in these studies.

### *Discussion*

These studies did not evaluate adult survivors of childhood abuse and neglect nor did they ask them about their internal experience of the relative importance of pleasure.

The subjects of this study commonly understood pleasure as a positive emotion. They defined pleasure as what is good: comfort, contentment, things going smoothly, something enjoyable, happiness, joy, fun, delight, and safety. Tugade and Fredrickson (2004) found that the experience of positive emotional granularity in trait-resilient people enhanced their ability to bounce back from negative emotional experience.

These subjects showed positive emotional granularity, the ability to express detailed and specific narratives of their positive emotional experience. The subjects in this study spoke in very specific and detailed ways about their pleasure. One subject wrote a letter after her interview with a long, elaborate list of the pleasurable experiences in her current life.

These subjects evidenced both a lifetime history of the capacity for pleasure and the enhancement of this capacity within the context of their psychotherapies. This may indicate that the nurturance of the capacity for pleasure is fundamental to both functionality and the restoration of the self. This subject deserves further study.

### *Implication #2*

How did these subjects define pleasure? Pleasure was experientially defined by the subjects. All subjects defined pleasure as variants of positive affects.

Subjects said that experiences that were safe, comfortable, fun, and enjoyable were pleasurable. Subjects spoke of pleasure being “what is good” and “something I loved to do.” Patient-subjects said their therapists’ reliable, consistent, predictable

availability, coupled with caring and compassion, “made me happy.” They also showed their pleasure in smiles, delighted expressions, and laughter.

The subjects made a clear distinction between definitions of pleasure and activities that were harmful, but provided distraction from pain, coping, and escapism. The latter were not retrospectively defined as inherently pleasurable.

The implication of this study is that definitions of pleasure were both complex and multi-faceted aspects of positive affects. Two major categories were delineated. Pleasure that derived from the idiosyncratic organization of the self, activities, and interests were often discussed. Pleasure in and with others in relationship was an even more predominant theme. All of these are *qualitative* aspects of experience. They did not discuss the amount of stimulus that was pleasurable or not to them. How these aspects of experience interface with self-capacities will be taken up later in the discussion of “finding a self.”

*Theoretical Views of Pleasure: How Do These Experientially Derived Definitions of Pleasure Compare to Definitions Offered in the Literature?*

*Freud*

Historically, theoretical formulations about pleasure precede research studies. Of all the theorists discussed, Freud has the most to say about definitions of pleasure. Freud was theorizing about pleasure from the inception of his work. Freud thought that emerging biological science would clarify our thinking.

“Biology is truly the land of unlimited possibilities. We may expect it to give us the most surprising information and we cannot guess what answers it will return in a few dozen years to the questions we have put to it” (Freud, 1920, p. 60).

Freud was theorizing that biological mechanisms drove human behavior, including our pursuit of pleasure. Freud (1905) saw libidinal energy as part of one of the primary drives organizing human existence. Tension build up of libidinal energy becomes his initial definition of unpleasure or anxiety, and tension relief of libidinal energy defines pleasure. Constancy is the aim.

Later, he refines his conception of pleasure beyond a simple reduction of tension as “the amount of increase or diminution in the quantity of excitation in a given period of time” (1920, p. 8). He goes on to discuss individual differences in regulatory capacity so that the experience of pleasure or unpleasure begins to be seated within excitation over time, endowment, and prior life experience. He notes that feeling tension itself can be pleasurable or unpleasurable.

Freud now defines anxiety not by tension build up, but as a response to danger—a warning, a signal. In this schema, individual differences exist in both how much stimuli overwhelms the individual and the effectiveness of the signal anxiety in warning of danger. Trauma results when these capacities to protect are overwhelmed. “Traumatic neurosis is a consequence of an extensive breach being made of the protective shield against stimuli” (Freud, 1920, p. 31). Freud indicates that the build up of libidinal tension, overwhelming experience and the individual differences in the desirability of different levels of excitation over time all affect the experience of pleasure.

Tension build up, overwhelming experience, and the individual differences in the desirability of different levels of excitation over time all affect the experience of or lack of pleasure.

These subjects do not define pleasure in the same ways as Freud. So did subjects define pleasure as tension relief? Certainly, these subjects do not discuss the relief of libidinal tension. They do describe the reduction of their anxiety when they felt safe. It was this reduction of anxiety, coupled with the feelings of relief and relaxation, or feeling at ease, that was described as pleasurable. The subjects not only said that safety made pleasure possible, but that safety itself was pleasurable.

These subjects contrast their traumatic experience with the pleasure they now feel in safe relationship with their therapists. These subjects do not speak of the *quantity* of experience at all. They do not speak to the amount of stimuli as a factor in libidinal or any other type of pleasure. Consistently, they speak of the *quality* of experience. For them, the *quality* of the experience is predominant in distinguishing pleasurable from unpleasurable experience.

### *Sroufe*

The issue of quality of experience brings us closer to Sroufe's (1995) contention. Tension itself is not seen as unpleasure nor does Sroufe see tension as a buildup of libidinal energy. Tension or arousal in the infant exists as a neutral platform; it is an indication of the child's attention being captured by some stimulus.

"Tension, as described here, is not always present and seeking discharge, and it is not necessarily aversive. Tension is a natural consequence of the infant's engagement of novel stimulation" (Sroufe, 1995, p. 92). Sroufe is observing babies.

“In a secure context,” Sroufe states (1995, p. 92), “infants actively seek to reproduce incongruous, tension-producing situations.” Sroufe’s (1995) work would indicate that the assessment of a stimulus as novel and not dangerous takes place in a relational context. “In a secure context, the tension produced by the same social approach may lead to positive responses” (Sroufe, 1995, p. 95). Some of the positive responses Sroufe (1995) discusses are smiling and laughing. He posits that these early positive responses “give way to more active involvement” (Sroufe, 1995, p. 99). The positive experience encourages further exploratory behavior, leading to “the tendency of the infant to move towards incongruity and to find *pleasure* in cognitive challenges” (Sroufe, 1995, p. 99).

Sroufe (1995) is arguing that the affect produced by stimuli depends upon the result of the interaction between the environment and the infant. This is not about the *quantity* of tension. The issue here is the *quality* of the tension. The safe context encourages the exploratory behavior of the infant, the infant’s pursuit of engagement with the novel stimuli that may lead to pleasure.

These subjects were adults and they reported their experience. They were not observed. They did not discuss tension. They did relate their experience of pleasure to safe excitement. Chapter IV discusses the myriad experiences subjects reported that were pleasurable. Subjects experientially defined pleasure by their pursuit of desirable activities and interests. They also defined pleasure in relationship. In both categories of pleasure, safety was of preeminent importance. There was pleasure in safety. They, like Sroufe’s babies (1995), could and did pursue what interested them, what they defined as giving them pleasure, given a safe context.

### *Fairbairn*

The idea of pleasure as being a secondary derivative of object seeking originates in the literature with Fairbairn (1944/1952), who contrasts his view to the classical Freudian position in declaring that libido is object seeking. In Fairbairn's view (1944/1952), the infant seeks objects or others, upon whom he is dependent for the satisfaction of his needs. Pleasure is seen as a substrate of this behavior.

Though Freud (1920) discusses multiple sources of pleasure in *Beyond the Pleasure Principle*, including repetition, novelty, and the restoration of equilibrium, neither Freud nor Fairbairn address the possibility that we may be both pleasure seeking and object seeking from birth. This sample implies that both may be true. They describe both pleasure in activities of interest and pleasure in safe relationship. They describe seeking and finding pleasure throughout their lives, even when their primary relational context was unsafe. Many of their early narratives were of solitary pleasure seeking. They, of course, are not speaking of infantile memory of experience. They do indicate that in these early experiences of pleasure they felt safe alone. For these subjects, safety is reported as a necessary context to their experience of pleasure, both for the independent pursuit of their interests and for their pleasure in the context of relationships.

### *Kohut*

Kohut does not address this possibility, either. He does discuss pleasure as tension relief. Before Kohut (1966) began to formulate self-psychological theory, he discussed the idea of tension relief being related to pleasure. "Pleasure is experienced when

psychological tension is relieved or when such relief is anticipated shortly” (Kohut & Levarie, 1950, p. 73).

However, Kohut is already describing tension in more general terms than Freud was in 1920. Tension for Kohut is not just the buildup of libidinal energy. Kohut (& Levarie, 1950) stated:

[E]nergies bound to a certain task become freed by and can now be employed in pleasurable discharge. When, after carrying a heavy load on one’s back, one is suddenly relieved of it the act of walking, which is usually a neutral experience on the pleasure-pain scale, becomes for a while definitely pleasurable. The amount of surplus energy freed by the removal of the load is discharged in exuberant motions, in extra elasticity of gait, and the accompanying emotion of pleasure (p. 73).

In his later formulation of self-psychology, Kohut (1977) turned more fully away from the drive theory definition of pleasure as tension reduction. Tension regulation is preserved in Kohut’s model with these modifications: tension regulation takes place as a relational phenomenon beginning at birth and proceeding throughout life. Kohut (1974) discusses both sensory pleasure, pleasure in pursuit of realistic goals that enhances self-esteem, and the necessity of a particular parental response to achieve these goals. “Under favorable circumstances (appropriate selective parental response to the child’s demands for an echo to and a participation in the narcissistic-exhibitionistic manifestations of his grandiose fantasies) the child learns to accept his realistic limitations . . . by pleasure in his functions and activities and realistic self-esteem,” (Kohut, 1974, p. 107).

These subjects do not define pleasure in the same ways as Kohut. These subjects do not discuss self-esteem. They do discuss pleasure in functions and activities that they can realistically achieve. They do discuss pleasure in the relief of tension sourced in psychological pain. They do discuss the historical absence of appropriate selective

parental responses and often discuss inappropriate parental responses that disrupt their pleasure or the possibility of pleasure. They also discuss the pleasure of being in safe relationship with therapists.

### *Csikszentmihalyi*

Csikszentmihalyi (1990) takes a different approach to defining pleasure. He culled his definition of flow from his original research interviews with successful individuals in a variety of fields. He has now accumulated dozens of studies on this optimum experience, which he calls flow.

Flow is not pleasure in his typology. He distinguishes pleasure from happiness and enjoyment. "Pleasure is a feeling of contentment that one achieves whenever information in consciousness says that expectations set by biological programs or social conditioning have been met" (Csikszentmihalyi, 1990, p. 45).

This is a very experience-distant definition. Csikszentmihalyi believes that "we can experience pleasure without any investment of psychic energy. It is for this reason that pleasure is so evanescent, and that the self does not grow as a consequence of pleasurable experience" (1990, p. 47). Csikszentmihalyi (1990) dismisses pleasure as a minor chord in his theory of what produces human happiness. He does not dismiss positive affect.

He contrasts pleasure to enjoyment that leads to the development of the self and that, in his research, is seen as an outgrowth of flow. Flow is defined as that experience in which "concentration is so intense that there is no attention left over to think about anything irrelevant, or to worry about problems" (Csikszentmihalyi, 1990, p. 7). "It

includes joy, creativity, and the process of total involvement with life” that he defines as “optimal experience” (Csikszentmihalyi, 1990, p. 3).

According to Csikszentmihalyi, “[F]ollowing a flow experience, the organization of the self is more complex than it had been before. It is by becoming increasingly complex that the self might be seen to grow” (1990, p. 41).

We will take up this discussion of the development of the self again later in this chapter. These subjects did not define pleasure in the same way as Csikszentmihalyi (1990). This optimal experience was not remarked upon. These subjects’ definitions of pleasure were always soaked in safety. Within a safe relational context, they found pleasure in comfortable, comforting, consistent, reliable contact; in expanded emotional expression; and pursuit of interests.

Csikszentmihalyi (1990) concurs that flow requires a safe interpersonal context. These subjects did not make fine distinctions between pleasure and enjoyment and optimal experience. We can wonder if chronic traumatic early experience has influenced their definitions. Does safety paired with comfort resonate more pleasurably for those who have been so injured? This study can only propose this question for further study.

### *Implication # 3*

Chapter IV further discusses the variety of ways that psychotherapy patients who were subjects in this study articulated a narrative describing the disruption of pleasure in their lives. The story of this disruption is told both by the patients themselves and by their therapists. The discussion illuminates the variety of external interruptions and assaults upon pleasure that this population experienced and ends with a discussion of the patterns of disruption that the subjects internalized.

Though these findings cannot elucidate the biological underpinnings of pleasure, the subjects certainly all felt that pleasure was important. All patient-subjects, despite severe maltreatment, have reported a history in which they experienced some pleasure throughout their lives. All patient-subjects sought to expand this experience, though most also found pleasure problematic.

The implication of these findings is that when historically safe relationships were not available, pleasure seeking did not cease, but was disrupted. Pleasure was truncated or sequestered. They became wary. Subjects discussed both the active and passive destruction of their pleasure by others. For some subjects, aspects of their experience of pleasure were annihilated. They also described how these disruptions to pleasure were internalized, how they became the disrupters of their own pleasure.

### *Theoretical Formulation About the Disruption of Pleasure*

#### *Kohut*

For Kohut (1972), perversions were a type of regression to autoeroticism, consisting of obsessive pleasure seeking that arises from fragmentation in the face of empathic failure as an attempt to manage disintegration anxiety. Kohut is discussing perverse sexual activity.

These subjects never discuss having pleasure in perverse sexual activity. Still, there is something of Kohut's (1972) idea of perversions echoed in less theoretical language through the descriptions subjects offered of their addictive coping mechanisms. Subject 5A discusses the multiple chemical addictions with which she struggled when she entered therapy. Subject 6A discusses his former use of angry music. Both say that these

behaviors, which they formerly found pleasurable, they retrospectively believe were not. Their views of their experience shifted over time. They both suffered the severe empathic failure of their mothers and did not have fathers available. Both report histories of severe maltreatment, including sexual abuse. They both suffered from extreme anxiety and saw their addictions as substitutions they used to compensate for the continuing lack of positive interpersonal resources in their lives.

They describe these experiences as attempts to manage anxiety, perhaps disintegration anxiety. They both did fragment and required multiple hospitalizations. They are both now stable and report having a large range of pleasurable activities and relational resources. One of these subjects, extensively quoted in the findings, wrote after her interview, saying that it was important to her that she clarify the distinction between pleasure and addictions. This subject would agree with Kohut (1972) that she had thought herself to be obsessively pleasure seeking. She would now say that she *appeared* to be pleasure seeking. Definitions of pleasure had changed for these subjects over time and with therapeutic treatment.

#### *Fairbairn and Freyd: Betrayal Trauma*

Freyd's (1998) theorizing and research address the same problem that Fairbairn (1952, p. 65) said resulted in the "moral defence" in abused children. Fairbairn (1952) concludes that sometimes being abused by a parent upon whom you are also dependent creates a dilemma for the child in which the abused child often sees themselves as the bad object, preferentially, to seeing the caretaking parent who abuses them as bad. If splitting

of good and bad objects occurs and is rigid in structure for defensive purposes, it is possible that feeling good will feel bad.

Freyd (1998) argues that this is a phenomenon of “betrayal trauma.” Given the relational dependence on a caretaking parent, knowing that the caretaking parent is also the abusing parent presents a dilemma for the child that frequently results in dissociation. The child seeks to keep good and bad elements of the dependent relationship separate.

Sometimes, experiencing pleasure can be a problem. If splitting of good and bad objects occurs and is rigid in structure for defensive purposes, it is possible that feeling good will feel bad. When a parentally abused patient feels pleasure with his or her therapist, that person may also feel especially bad. Conflicted and negative emotions when experiencing pleasure were illustrated in Chapter IV.

Patient-subjects report that consistent, reliable, caring encounters produce a pleasurable interpersonal security in the relationship. Though this finding predominates in the narratives, it is not the only reaction expressed. While not undermining the import of this finding, we must also remember that experiencing pleasure was not always a positive experience for these patient-subjects. Perversions of pleasure were not the only problem with pleasure described by subjects in this study.

The experience of pleasure was reported to be disrupted both *historically* and disrupted *currently* by internalized patterns of disruption. Sometimes experiencing pleasure was the problem

As the extensive trauma literature attests, attaining a secure therapeutic alliance is a vastly complex enterprise (Blizzard, 2003; Briere, 1992; Chu, 1998; Freyd, DePrince, & Zurbriggen, 2001; Lyons-Ruth, 1996; McCann & Pearlman, 1990; Putnam, 1989, 1997;

Salter, 1995; Van der Kolk, McFarlane, & Weisaeth, 1996; Wilson, Friedman, & Lindy, 2001). This study also attests to this difficulty.

One therapist succinctly labeled this dilemma as having to do with pleasure itself. She says, “I think as she and I have fostered our attachment, she’s also more anxious and dissociative about being here because she’s growing more aware of the comfortable thing we have and there are times that in itself scares her and she needs to put up a wedge.”

This is a beautifully stated articulation of one of the ways that pleasure becomes problematic. This therapist is making a very nuanced observation. On the way to a secure Attachment, her patient’s pleasure, “the comfortable thing we have,” scares the patient. This is a much less idealized picture than one in which a safe, reliable, consistent relationship simply builds more security. We see here that positive affects, possibly pleasure, can also be problematic in and of themselves.

One of the patient-subjects echoes this dilemma when, after telling the researcher that she is conflicted about experiencing pleasure, she makes the following statement. “I think he’s a wonderful therapist. I don’t think that we would be a better one in the world, but I don’t think...I think he’s pretty clueless about what my life is like.” This clinical pair had been working together for over ten years. There are many markers of improvement in the quality of her life that she volunteers in the course of the interview.

So it is worth noting the conflict she has making a clear statement of her attachment to her therapist. These comments imply again that while there may be no therapeutic gains without pleasure, pleasure itself can be an obstacle to connection, a source of fear that carries with it the expectation of injury. This implication of the study is that trauma disrupts the capacity for pleasure both *historically* and *currently*. The

internalization of these previously historical disruptions continues to manifest in the lives of these subjects post-traumatically.

## The Crossover: Chapter VI

### *Findings*

“Chapter VI: The Crossover” compares the narratives of the patient-subjects with those of their therapists. Patient-subjects consistently reported that they volunteered for this study because of the strength of their alliance with their therapists. These were good, working clinical pairs. The depth of their alliance can most clearly be seen here. Every clinical pair of subjects told, thematically, the same narrative. All the patient-subjects were interviewed first. Interviews with their therapists were scheduled after the patients had spoken to the researcher. The researcher purposely chose to hear the patients’ stories first.

Upon review of the transcripts, a remarkable congruence was found between the stories told by therapists and patients. How the stories were told differed, yet in a relatively brief interview of approximately one and one half hours, in response to the most minimal of prompts, therapists and patients consistently told the same story. When directed to tell the researcher about the patient’s experience of pleasure, both offered essentially the same story. Even when these narratives wandered into the territory of the patient’s pain, both patient and therapist chose the same particular stories to tell.

### *Implications*

There are two implications embedded in this chapter's findings.

1. The implication is that the congruent correspondence between these pairs is an indication of validity.
2. The implication is that the overlapping narratives of clinical pairs may be an indicator of a strong therapeutic alliance.

### *Implication #1*

Both members of the clinical pairs told essentially the same stories of both the patient's experience of pleasure, of disruption of pleasure, and of what was therapeutically useful. One way to evaluate validity within narrative research is to evaluate the degree of congruent correspondence between different narratives of the same events. The implication of this study is that the high degree of congruent correspondence between clinical pairs is an indicator of validity.

### *Validity: Congruence and Correspondence*

Riessman (2009) proposes that all assessments of validity are situated within a context of particular epistemologies and theories. She says, "[T]he validity of the project should be assessed from within the situated perspective and traditions that frame it" (2008, p. 185). To investigate the trustworthiness of the data, Riessman (2008, p. 186) starts with the proposition "that narrative truths are always partial—committed and incomplete." This study interviewed subjects only one time. Though some subjects engaged in follow-up communication with the researcher, each subject essentially told

their story one time. These transcripts must be seen as a narrative told in one moment in time.

Therapist-subjects were interviewed separately after their patients' had completed their interviews. Interviews were held as confidential within pairs. The interviewer never discussed the patients' interview with their therapists. Still, the clinical pairs so consistently told the same story that the interviewer was never confused about which patient belonged with which therapist.

Correspondence was high. The sequences of events reported by the patient-subjects matched the therapists' narratives. The differences even in the content details of the narratives tended to be small. One pair told the story of the patient's volunteer work. Another pair talked about the patient's evolution of pleasure from fantasy to reality. Another pair told about art projects they engaged in together.

The pairs also expressed similar affect when they told these stories. What made one member of the pair happy, made the other happy, too—or sad, or upset, or angry. The correspondence in congruent affect was also notable.

### *Implication # 2*

Patients and therapists were interviewed separately. Patients were interviewed first. It was always clear to the interviewer which patient belonged to which therapist. The stories the clinical pairs told in response to minimal prompts were thematically and affectively distinct. Overwhelmingly, they both told essentially the same stories. The implication is that the similarity of narratives may reflect the degree of their therapeutic alliance. This congruence may be an indicator of strong therapeutic alliances between pairs.

### *The Therapeutic Alliance*

What are the possible theoretical understandings of this finding? One way to begin understanding this implication is to see the correspondence between the therapists' narrative and the patients' narratives as a manifestation of the therapeutic alliance. Both subjects in the clinical pair privilege the same stories about their relationship when discussing the patient's experience of pleasure and therapeutic repair.

Freud (1912) didn't use the term therapeutic alliance. However, he was an early indirect commenter on the therapeutic alliance, indicating that some conscious positive transference of affectionate feelings was perhaps necessary for a successful analysis. Given this beginning, more recent theory has continued to expand this concept.

Bordin (1979) theorized that the therapeutic was made of three intermingling components: tasks, goals, and the bond between the therapeutic pair. The tasks here are conceptualized as the therapeutic tasks, that is, how the clinician must engage to create a psychotherapy. The goals are what they hope to achieve. The bond is the degree of positive affective response that each member of the pair has for the other. If the clinical pair is agreed about tasks and goals and has a deep bond with each other, Bordin (1979) would see this as evidence of the strength of their therapeutic alliance.

When interviewing therapists, the researcher had no difficulty recognizing their patients. Upon review of the transcripts, a remarkable congruence was found between the stories told by therapists and patients. How the stories were told differed, yet in a relatively brief interview of approximately one and one half hours, in response to the most minimal of prompts, therapists and patients consistently told much the same story.

When discussing their psychotherapies, clinical pairs each had a unique story to tell. These stories may represent their joint vision of the tasks and goals of their psychotherapy. This can be seen as indication of the therapeutic alliance.

In addition to the congruent reportage of events in time, narratives were also rich in affective detail. Patients and therapists not only told the same stories over and over again, often with the same details, they also told the same stories with the same affect. This would be seen by Bordin (1979) as evidence of the affectionate bond between them.

Ehrenberg (1992, p. 97) situates the alliance in the “necessity for a collaborative relationship.” She says that the collaboration is built not only upon the therapist’s empathy, but within the therapist’s willingness to take risks in being emotionally transparent. This “establishes a level of honesty and openness that can be significant in and of itself” (Ehrenberg, 1992, p. 97).

Perhaps this, too, can be understood as a feature of the therapeutic alliance, the ability to be open and honest with each other. Interviews were completely confidential. The researcher never spoke to either member of a clinical pair about the other’s interview. Subsequently, many clinical pairs reported that they spoke at length to each other about their interviews after both parties had completed their interviews. Interviews were perhaps seen as grist for the therapeutic mill. They robustly made use of what they had experienced in the interview process. They trusted each other enough to discuss the perspectives they had offered in the research.

Patient-subjects spoke extensively about their early personal histories, about their lives now, and about their psychotherapies. Therapists and patients were all asked to speak about the patient’s experience of pleasure. This directive would account for the

territory of their oration. But it may not account for the depth of overlapping detail in these narratives. It is possible to interpret the data in this study to indicate not only that the therapeutic alliance is of importance in the success of a therapy, but that the therapeutic alliance itself may be that success.

## Out of Frame: The Treatment Frame: Chapter VII

### *Findings*

“Chapter VII: Out of Frame” discusses the unexpected finding when moments of import occurred, wherein the therapist-subjects stepped out of their usual therapeutic frame. There is a long tradition in the field stressing the importance of maintaining an ethical and therapeutic treatment frame. The therapist-subjects in this study all clearly spoke to their beliefs in the necessity of a clear treatment frame.

Although all psychodynamic practitioners, they varied in the particulars of how they constructed that frame. Of note in the data was the number of therapists who commented on a particularly significant therapeutic moment of engagement outside their normative frame. For every therapist-subject who told an out-of-frame narrative, their patient told their own version of this *same* moment. The same moments that surprised the therapists were experienced by their patients as pivotal to the success of the therapy. Though the moments themselves were often constructed out of crisis, the pleasure that these patients had in the felt responsiveness of their therapists was extensive. These therapists’ ability to empathically step out of their usual treatment frame was experienced as deeply meaningful and pleasurable to their patients.

### *Implications*

There are two implications embedded in this chapter's findings.

1. One implication is that this finding also shows congruence Correspondence, which is an indication of validity.
2. The other implication of this finding is that these therapists' ability to empathically step out of their usual treatment frame was therapeutically useful.

### *Implication # 1 and #2*

Over a third of the therapist-subjects interviewed told of a moment in treatment in which they found themselves stepping outside their usual therapeutic frame to intervene with their patient. In every instance where a therapist told the story of this out-of-frame moment, their patient had spontaneously already told the researcher the same story. These stories were often about a moment of crisis in the treatment. Still, every patient retrospectively expressed a great deal of pleasure in the narrative. Both therapists and patients saw these moments as critical moments in treatment, when therapeutic relationships were further solidified and patients felt an increased sense of safety in the relationship. The two implications are that, again, these are indications of validity and that the therapists' stepping out of their usual treatment frame was therapeutically useful.

### *Treatment Frame Theory*

The concept of therapeutic alliance is related to an associated construct, that of the treatment frame. The need for both a therapeutic alliance and a clear treatment frame, says Moorey (2006, p. 241), comes from “principles which were originally developed within psychoanalysis that are applicable to any form of ‘therapy.’ As we shall see, attending to the frame and the alliance is essentially about being clear about the parameters of the service being offered, and what is being asked of service providers and service users.” Moorey’s (2006) definition of the treatment frame both implicitly argues for the importance of maintaining a treatment frame and the need for clarity and specificity in how the treatment will and will not be offered.

There is a long tradition in the field stressing the importance of maintaining an ethical and therapeutic treatment frame. In a classical Freudian analysis, the treatment frame includes the mandate that the patient say everything on his or her mind, free associate. Freud (1913) considered this non-negotiable. Ogden (1996) argues that this non-negotiable can become a hindrance to treatment itself.

This is one example of a long debate about what should be the parameters of this frame. Langs (1979) argues for a secure, reliable, and static frame. Casement (1985), while agreeing as to the importance of the frame, argues for a responsive frame created by the careful, reflective process on the part of the therapist to each particular patient and the moment being engaged in the therapeutic process. These are two polarized positions on a spectrum of thinking about treatment technique.

Ehrenberg (1992, p. 64) echoes Casement’s position. Though she is speaking specifically of analytic psychotherapies, when the subjects in this study were not in analysis, her comments are relevant here. “The traditional criteria such as frequency of

sessions, use of the couch, preserving the ‘frame’ as traditionally defined, free association, even analysis of transference and resistance do not guarantee an analytic process—nor do variations in the maintenance of the frame necessarily preclude one. The same intervention can be inspired in one context and detrimental in another.”

The interventions described in “Chapter VI: Out of Frame” are of the inspired variety. The therapist-subjects in this study all clearly spoke to their beliefs in the necessity of a clear treatment frame. Although all psychodynamic practitioners, they varied in the particulars of how they constructed that frame. Of note in the data was the number of therapists who commented on a particularly significant therapeutic moment of engagement outside their normative frame. For every therapist-subject who told an out-of-frame narrative, their patient told their own version of this *same* moment.

The same moments that surprised the therapists were experienced by their patients as pivotal to the success of the therapy. These were deeply pleasurable experiences for the therapists and patients. They often smiled or laughed as they told about these moments.

Their affect is interesting because the moments of moving out of frame mostly stem from a crisis or painful experience. Listening to these stories is much like listening to *good* war stories—stories in which danger was skirted and camaraderie triumphs. The patients felt safer in relationship afterwards. There is pleasure in the victory achieved together. The patients’ capacity to experience pleasure was enhanced. They describe feeling more freedom afterwards in their relationships with their therapists. They feel pleasure in this new mobility. And this freedom extended to their delight in the further exploration of other relationships with friends and family.

The subjects in this study, both therapists and patients, tell stories not of therapeutic impulsivity, but responsiveness. These therapists do not step out of frame easily. They are mostly reluctant and always thoughtful about their movement outside of their normative parameters. The therapists are attuned to their patients, responsive and reflective about what they are doing. Much like Ogden (1996) and Casement (1991) and Ehrenberg (1992), they do not give up their treatment frame; they alter the frame to fit this moment in the therapeutic life of the patient. They exemplify the difference between reactivity and responsivity.

### Repair: Everything is Possible: Chapter VIII

#### *Findings*

“Chapter VIII: Repair: Everything is Possible” discusses the relative importance of pleasure in therapeutic repair. Is pleasure important in the therapeutic paradigm of repair for survivors of chronic childhood abuse and neglect? Subject 5B beautifully states this finding. She says, “I think pleasure is a piece of fulfillment in life. And I think it’s the capacity to feel pleasure that is a key piece, because if I can’t take pleasure in anything, then how do I know what has meaning for me? What is motivating, what creates meaning?” It is important to rearticulate here, because these subjects linked a successful therapy completion with the restoration of the capacity for pleasure. As one subject poignantly said, “I don’t want to die until I have figured out how to solve this, how to get better, how to find out what you’re talking about.”

“Getting better” seems to start with the pleasure that glues the therapeutic alliance. Mutual pleasure is evidenced by the positive affective bond between members

of the clinical pairs. The pleasure that they found in each other may be the most important feature of what was reparative.

### *Implications*

There are four implications embedded in this chapter's findings.

1. One implication of these findings suggests that the creation of the therapeutic alliance itself was reparative for these subjects.
2. A second implication is that empathic rupture and repair was not seen as an element in therapeutic repair of childhood trauma. Empathic rupture was either insignificant or so seamlessly repaired as to be rendered unconscious.
3. The third implication is that the pleasurable affective bond between clinical pairs helped develop a secure attachment relationship that allowed subjects to further their experience of pleasure in the world at large.
4. A fourth implication is that mutual pleasure is a significant factor in affect regulation, helping to form a therapeutic alliance.

### *Implication # 1*

All clinical pairs studied had a strong pre-existing therapeutic alliance. The patient-subjects said that they were able to participate in the research study because they trusted their therapists and their therapists' judgment about the researcher. The clinical pairs all spoke frequently about "the connection" they felt with each other, the safety they felt in each others' presence. They spoke about ways that "the connection" repaired the ramifications of previous interpersonal traumatic injury. The implication is that the creation of the therapeutic alliance itself was reparative.

### *The Therapeutic Alliance Revisited*

Safran and Muran (2000, p. 1) state that "after approximately a half century of psychotherapy research, one of the most consistent findings is that the quality of the therapeutic alliance is the most robust predictor of treatment success." The relational bond, which is the therapeutic alliance, they consider necessary to the therapeutic process. Holding the relational bond is seen as pivotal to therapy through the creation of new interpersonal experience. New relational experience is seen as reparative of old interpersonal traumatic injury. They argue further that it may be that the making of this alliance is a substantive aspect of what is therapeutic.

### *Implication # 2*

In this study there was an absence of discussion of rupture within these clinical pairs. While patient-subjects discussed rupture in the context of previously unsuccessful therapies, they did not discuss injury or rupture in the context of their relationships with their current therapists. The implication is that empathic rupture and repair was not seen as an element in therapeutic repair of childhood trauma. Empathic rupture was either insignificant or so seamlessly repaired as to be rendered unconscious.

### *Empathic Rupture*

This study does not offer much data on the repair of ruptures. The only data that addresses this issue is in those interviews where subjects spoke of previous unsuccessful therapies. What we know from these narratives and from the demographic data is that these patient-subjects all had multiple, previously unsuccessful therapies. The subjects who spoke of their previous therapies did speak of irreparable ruptures.

These subjects did not much address the issue of ruptures within their current psychotherapies. They spoke more about moments when they feared a rupture. When patient-subject 5A came into her therapist's office drunk, she expected a bad outcome. She found her therapist's compassionate, protective response pivotal. She stopped drinking. For her, as for many others in this study, it was not the repair of ruptures that was meaningful.

What was meaningful and pleasurable was the consciously unexpected kindness, the lack of a punitive or humiliating response, the absence of rupture, the caring. This is interesting, both because this patient population of subjects is a highly traumatized

population in which the literature would indicate that therapeutic breaches would be *more* common place

*Safran and Muran.*

Safran and Muran (2000) review a vast literature commenting upon not only the therapeutic alliance, but the repair of breaches in the alliance. They go on to argue that ruptures to the alliance are not only inevitable, but “that one of the most important therapeutic skills consists of dealing therapeutically with this type of negative process and repairing ruptures” (2000, p. 1). The making of the therapeutic alliance is seen as deriving primarily from the process of rupture and repair. Rupture is seen as inevitable in the therapeutic relationship. The therapist learning how to negotiate these ruptures to create repair is understood as clinically pivotal.

*Kohut.*

Kohut (1971, 1977) viewed resistance as any attempt to avoid the repetition of traumatic experience. This was thought to be a healthy expression of self. Therefore, the repair of the empathic lapse was thought crucial to successful treatment.

According to Kohut (1978, p. 928), self-cohesion was restored through “structure building via transmuting internalization. This process can only take place in a therapeutic milieu that is psychologically neutral, that is, in an atmosphere free from gross psychological overstimulations and rejections. The analyst tries to be in empathic touch with the patient’s inner life at all times, with the result that his failures are sufficiently small and of sufficiently short duration to allow the patient to respond to them via structure building.”

*Discussion*

It would be reasonable to conjecture that empathic failure would be a significant feature of these psychotherapies. This is not what subjects reported. The subjects did report empathic lapses within their previously unsuccessful psychotherapies. So perhaps the empathic breaches within their current psychotherapies were sufficiently small and of sufficiently short duration as to retrospectively lack impact. Maybe the empathic lapses are just not remembered.

It is also possible that the structuring of the interviews as a discussion of pleasure led subjects to focus on positive affective experience to the exclusion of negative affective experience. The data does not support this conclusion. All patients extensively discussed painful, distressing experience. They did not discuss the painful experience of empathic breaches within these psychotherapies.

We might understand this finding as an artifact of idealization. Maybe these subjects had found a good enough idealizable other in their therapists and either did not have negative feelings about their therapists at the time of their interviews or did not want the researcher to think badly of their therapists. Maybe these therapists who reported having so much pleasure in their patients also idealized their patients.

One therapist in the study, speaking about a former therapist's difficulties working with her patient, said, "[I]t seems that the previous therapist would not disclose any information about her personal life, nothing. And, I don't know if she was concerned about the client overstepping her boundaries, but I don't think she's like that. I mean, she doesn't, in my opinion, so if I'm gonna be off and gonna be taking vacation time, I

prepare her for that. I will tell her where, I'll say I'm going to Michigan or whatever.”

This therapist clearly did not feel that her patient was overly or inappropriately intrusive. She seemed puzzled that the patient's former therapist had felt a need to tightly regulate information.

This therapist does not portray an idealization of her patient. Mostly, the subjects' descriptions of each other did not reflect idealization. Therapists told stories of when they felt challenged by difficulties with their patients. Patients saw themselves as challenging, but expressed that they felt their therapists were consistently allied with them.

We must consider the possibility that either there was little to no empathic failure in these therapies or that, retrospectively, the empathic breaches were so effectively repaired that they no longer exist as a significant feature of the therapy narrative. One patient reported that she left therapy with her current therapist for a while. She never told the researcher why she left. Instead, she told the story of why she came back. She said that her therapist never gave up on her. The therapist repetitively left her phone messages, saying she was holding her place, that she would like to see her again, that she could come back in whenever she was ready.

She said, “I guess I had to make sure she was a person that I could disclose information to and feel really comfortable with her. I had stopped going and she would call me and ask me what was wrong to encourage me to come back. She was pretty persistent, so I did. And we began to pick up where we left off. It was during that time in therapy with her that I remembered being molested by my uncle. And, I couldn't, and then the flashes and everything, kind of made real sense. I think I just had escaped from this world and just created a safe world for myself. Uh, my parents never, never knew.”

### *Implication # 3*

Both patients and therapists spoke frequently about the pleasure that they had in relationship with each other. The patients felt that their therapists liked them. Some felt that their therapists loved them. The therapists also spoke of liking and loving their patients. They all spoke about feeling safe and secure with each other. The patient-subjects commented over and over again with pleasure on the reliability, consistency, predictability, and compassionate caring of their therapists. The clinical pairs all felt secure in their relationships with each other. This security was seen as what made “everything possible.” The third implication is that the pleasurable affective bond between clinical pairs helped developed a secure attachment relationship, which allowed subjects to further their experience of pleasure in the world at large.

### *Attachment*

*Bowlby: Attachment theory.*

While Bowlby’s (1969) initial work speaks in ethological terms of infant’s need for optimal proximity, he later expresses his understanding that secure attachment in human beings exists within the relational field. Secure attachment requires safety, and an interpersonal connection, a good relational bond. He goes on to say, “[A] feature of attachment behavior of the greatest importance clinically, and present irrespective of the age of the individual concerned, is the intensity of the emotion that accompanies it, the kind of emotion aroused depending upon how the relationship between the individual attached and the attachment figure is faring. *If it goes well, there is joy and a sense of security,*” [Italics added] (Bowlby, 1988, p. 4).

Embedded in this idea of safety and connection is the implication that within these therapies, patients were able to build a secure attachment with their therapists. The patient-subjects spoke about the safety they felt with their therapists. Both therapists and patients relay a deep sense of connection to each other, pleasure in and with each other. The patients talk about their therapists' reliability, consistency, and predictability. All of these ingredients of a secure attachment are commented upon both by the subjects and in the literature by Bowlby (1969, 1988) and Ainsworth (1969) and Main (1981).

*Mitchell: Relational theory.*

Both relational models reviewed in the literature hold as an implicit premise that a secure attachment is a necessary condition of a therapeutic alliance. Mitchell (1988, p. 289) sees all relational theorists as starting from the same premise that "the pursuit and maintenance of human relatedness is the basic maturational thrust in human development." This may be seen as an achievement of the therapy, rather than a precondition to therapeutic engagement. As such, clinical pairs are seen as achieving a secure attachment.

*Discussion*

These findings strongly support the contention that elements, such as safety and reliability, which some theorists indicate are necessary to produce a secure attachment, were critical to making a "connection." The data indicates that consistent compassionate connection predominates in creating therapeutic potential. This requires safety. These subjects talked about safety being pleasurable and safety creating the possibility of

pleasure. Safety was a feature embedded in the *quality* of the therapeutic relationship, “the connection.” Patient-subjects did not use the word attachment to describe their relationships with their therapists. They spoke of “connection.”

Connection was a word frequently used by both therapists and patients, although patient-subjects spurned the word attachment. Connection and attachment, when discussed by therapists, was created out of mutuality; it was bi-directional. Not only was it important to patients that they had pleasure in the company of their therapists, but it was also important that their therapists had pleasure, too. Therapists also frequently mentioned their pleasure in being with their patients.

The patient-subjects speak repetitively about the pleasure of the connection. While the patients did not use the theoretical language of attachment theory, some therapists spoke explicitly about attachment. These subjects speak both to the problem and the potential of making a secure attachment with such severely traumatized individuals. One therapist said, “He needs the attachment between us; I guess it carries him and allows things to happen.” She sees the secure attachment as the necessary fertile soil of the psychotherapy. Another therapist concurs. He states that, “I think her attachment to me is perhaps the most important thing there.”

The patient-subjects primarily found security in connection not in what their therapists said, but in what they did. These patient-subjects watched their therapists closely. Safety certainly consisted of not being physically or sexually harmed. But security derived from more than bodily safety.

Beyond these basic parameters, patient-subjects talked about being believed. Several felt that their former therapists had been dismissive, minimizing or disbelieving

their reports of abuse. They also spoke to the importance of telling their stories and having their therapists show compassionate interest. One subject says when talking with her therapist about the abuse, her therapist was kind and “she’s not afraid to remember with me.” It was critical that this form of caring was consistently, reliably, predictably available.

Pleasure and security in connection were found in the sometimes extraordinary lengths therapists were willing to go to be responsive to the needs of their patients. This was exemplified in “Chapter VII: Out of Frame.” Though told from different perspectives, both therapists and patients knew these events to be of extraordinary importance in their healing. Patients were retrospectively delighted in their therapists’ behavior. These experiences spoke to the depth of their therapists’ commitment.

Therapeutic interpretations were rarely mentioned. Even therapeutic verbiage was infrequently noted. Patient-subjects did not talk much about what their therapists said. They spoke about what their therapists did. Those verbal exchanges reported were given meaning by the context. So when Subject 1A reports that it was important to her that she could ask her therapist questions repeatedly, she states that she likes that her therapist will answer her and that “she doesn’t make me feel stupid.” Freedom from humiliation was one form of safe connection reported, “warmth and patience,” as one subject said.

As these subjects’ felt more secure in their therapeutic relationships, they became more exploratory. They discussed not only the expansion of pleasure within the context of their therapeutic relationships, but the additional expansion in exploration of relationships and new experience outside of the therapeutic milieu. Pleasure seeking was expanded by a secure relational context. Subjects found pleasure in both pursuit of their

own interests and in the secure relationship itself. Both contributed to the repair of traumatic injuries.

#### *Implication # 4*

As subjects defined pleasure, they spoke about a wide range of positive affects. The pleasure that they found in the company of their therapists expanded over the course of their treatments to finding pleasure in the company of others. They felt soothed in the company of their therapists and felt pleasure in being soothed. Subjects spoke about both their difficult traumatic histories and the pain of discussing these histories with their therapists. They also spoke about the importance to them of discussing these painful histories and how the soothing pleasurable presence of their therapists made it possible to have these discussions. The patient-subjects found their therapists' caring, affection, and humor pleasurable and regulating. In the presence of this positive affective milieu, their anxiety decreased, unbearable affect became manageable, and their bond deepened.

A fourth implication is that mutual pleasure is a significant factor in affect regulation, helping to form a therapeutic alliance.

#### *Relational Theories of Affect Regulation and Expression*

##### *Mitchell.*

Mitchell (1988) divides relational theory into two theoretical models. The first, which he labels the developmental-arrest model, posits a theory of developmental arrest and repair through provision by way of interpretation and self-psychology. Mitchell says, "In the developmental-arrest model the therapeutic action works to heal the paralysis and distortions generated by the interferences in that first (infantile) relationship" (Mitchell,

p. 285). Mitchell's (1988) second model of clinical theory is relational-conflict theory. This perspective emphasizes the child's creation of a constrictive interpersonal world derived from what is available in early relationships. In the relational-conflict model, repair is found through reenactment and the co-creation of new relational experience (Mitchell, 1988). Mitchell says, "[T]his model locates the central mechanism of analytic change in an alteration in the basic structure of the analysand's relational world" (Mitchell, 1988, p. 289). Relational-conflict model has been elaborated upon by many theorists, including Ehrenberg (1992) and Maroda (1998). Relational-conflict theory would hypothesize that both re-enactments and co-created new relational experience is the vehicle for change.

This data is retrospective, not observational. Subjects reflect upon their historical experience of their psychotherapies. Even those currently engaged in treatment are talking about moments now past. Just as the data here has little to say about the repair of empathic breaches, re-enactments are generally not discussed. As this data gives us no live information about the therapeutic process, we are left with many unknowns about what in the process was efficacious. These subjects report that consistent, reliable, caring encounters produce a pleasurable interpersonal security in their therapeutic relationships.

### *Affect Attunement: Relational Theories*

#### *Ehrenberg.*

What does manifest in the data is the persistence with which patients and therapists discuss their mutually positive affective experience. The therapeutic power of sustained positive affective interaction is fundamental to *all* relational theorists. Both

Ehrenberg (1992) and Maroda (1998) see intimate affective experience as necessary to therapeutic repair. Ehrenberg (1992) says:

From an interactive perspective, the critical issue inevitably is whether the patient is touched or reached in some significant way so that some *internal* process of *affective significance* is set in motion and so that some internal psychic change occurs . . . we recognize that our *understanding of this mutual impact can only evolve out of the work and requires the collaborative responsiveness of both* (p. 65).

There are a number of critical points Ehrenberg (1992) is making here. She is claiming the import of affective experience in making therapeutic change possible. She theorizes that these affective moments must take place in the psychotherapy, between the patient and therapist collaboratively. This is the intimacy of which she speaks. In her model, it is not enough for patients to tell their therapists about their emotional life and have therapists interpret these expressions. The clinical pair must live that emotional life together and thereby create new affective experience.

*Kohut.*

This concept is not fundamentally different than Kohut saying, “We must differentiate between two levels (a) empathy as an information gathering activity, and (b) empathy as a powerful emotional bond between people” (1982, p. 397). The powerful emotional bond is the mutual impact of affective significance.

*Maroda.*

Maroda (1998) applies Schore’s (1993, 2003) research to clinical theory. She cogently argues that transparent emotional expression on the part of the clinician is

neither an error nor a hindrance, but in fact a therapeutic necessity. Maroda (1998, p. 66) says, “[T]he mutually affective moment constitutes what is therapeutic between analytic therapist and patient.”

### *Discussion*

Kohut’s (1982) model emphasizes the development of the clinician’s capacity to sustain an empathic alliance. Mitchell (1988), Ehrenberg (1992), and Maroda (1998) emphasize the co-creation of new affective experience. These fine lines may not be discernable in the data.

We have already discussed a number of features of psychotherapy that subjects found reparative of the capacity for pleasure. In the self-psychological model, pleasure would be viewed as deriving both from tension reduction and from “appropriate selective parental response” (Kohut, 1974, p. 107). We have seen in this data the depth and consistency with which clinical pairs discuss their empathic connection. We have wondered if the lack of discussion of empathic breaches may reflect failures that “are sufficiently small and of sufficiently short duration to allow the patient to respond to them via structure building” (Kohut, 1978, p. 928). We will return to this issue of structure building later in our discussion.

What happened in these therapies that positively impacted the patients’ elaboration of the capacity for pleasure? “The mutually affective moment” is vividly portrayed throughout these interviews. The heartbeat of these findings is the mutually affective moment. What helps is always embedded in a strongly positive affective collaborative moment. One could randomly look at almost any interview for the moments

in which the subjects are speaking about therapeutic repair and find a discussion imbued with the affect of both therapist and patient. They are often in the therapeutic moment, experiencing highly charged negative affects: pain, grief, horror, anger. But in doing so safely, together, they also report experiencing pleasure. When these subjects speak about these affectively charged moments, whatever the content, they show and tell us the pleasure they have in what has transpired.

### “Finding a Self”: Chapter IX

#### *Findings*

“Chapter IX: Finding a Self” discusses the crucial development of a self to the elaboration of the patient-subjects’ capacity for pleasure. The patient-subjects repeatedly talked about the importance to them of “finding a self.” Patient-subjects did experience pleasure earlier in their lives and they did have a nascent sense of self prior to entering treatment. It is the pairing of the development of that self with the elaboration of their capacity for pleasure that these subjects spoke to over and over again.

It is interesting to note that the researcher made no conscious attempt to facilitate a conversation about the development of self across the life of these therapies. Subjects were never asked if they experienced a change in their identity over time. They were not asked about their capacities for self-soothing or affect regulation. They were not asked about whether or not they felt they could initiate or pursue interests of their own.

This topic arose spontaneously in the context of talking about pleasure and the problems they had experiencing pleasure. Discussing pleasure for these subjects was so intricately interwoven with the fabric of identity that the importance to them of finding a self emerged over and over again in the interviews. Upon doing a word search, the

researcher was astonished to find in the interview transcripts that subjects had used the word self approximately 400 times.

Various steps along the way to finding a self were enumerated. The patient-subjects speak to their experience of having others interfere with finding themselves. The subjects then go on to describe the importance to them of finding a self. They discuss seeing “glimmers” of who they might become. As they move towards describing the journey, the hard work of finding a self, they keep returning to the topic of pleasure. They tell us again and again that pleasure requires a self. Without a self, pleasure is like a suit of clothes without a body, all dressed up with no one inside.

We have already seen that a safe place from which to explore is constructed not only from the lack of malicious injury or indifference, but from the affectively engaged moments that provide the pleasure of comfort, security, and empowerment.

### *Implications*

There are three implications embedded in this chapter’s findings.

1. The first implication of these findings is that the elaboration of the capacity for pleasure may be dependent upon the further development of other self-capacities.
2. The second implication of these findings is that these self-capacities are elaborated within the medium of positive affective experience or pleasure.
3. The third implication is that within these positively charged affective experiences not only is there pleasure in reduced anxiety and an enhanced affective range, but pleasure in the creation and expression of new self-capacities.

*Implications #1, 2, and 3*

All three implications of these findings are interwoven. They must be viewed in conjunction with each other. Patient-subjects talked repeatedly about “finding a self.” So did their therapists.

Patient-subjects talked about longing, a desire for a self. This desire and its realization were inextricably interconnected with pleasure. They found pleasure when they were more affect regulated. They were more affect regulated when they could tolerate more painful affects. They could tolerate more painful affects when they felt soothed by their therapists’ patient, predictable caring. When they were more regulated, they felt more pleasure and were more able to reflect upon their experience. When they felt more regulated, they felt more pleasure. When they felt more able to reflect upon their experience, they felt “empowered” with a sense of agency. As these self-capacities were elaborated, they felt more as if they had *a self*. When they felt as if they had *a self*, they felt more like there was a someone who could experience pleasure. These are not linear events. No subjects talked about a linear trajectory of events that led to “finding a self.” Many subjects felt that they were still in the process of “finding a self.” These implications are reciprocal.

These implications are that the elaboration of pleasure is dependent upon the development of self-capacities for affect tolerance, regulation, reflective function, and agency within a medium of positive affective experience/pleasure, which creates new self-capacities.

*Self-Capacities*

Self-capacities has been a topic of research and theorizing that is especially important to authors studying childhood abuse and maltreatment (Briere & Runtz, 2002; Dieter, Nicholls, & Pearlman, 2000; Fonagy & Target, 1996, 1998; McCann & Pearlman, 1990; Palesh & Claussen, 2007; Pollack & Slavin, 1998; Putnam, 1989, 1997; Schore, 1994, 2003; Wilson, Friedman, & Lindy, 2001). Wilson, Friedman and Lindy (2001) see trauma as an injury to self-structure, leading to fragmentation, destabilization, and the lack of capacity to self soothe.

McCann and Pearlman (1990, p. 20–21) use constructivist self-development theory to posit “four self-capacities drawn from the self-psychology literature (Kohut, 1977) important to trauma survivors. The first is the ability to tolerate and regulate strong affects without self-fragmentation or acting out.” Affect regulation theory was explored and expanded upon by Schore (1994, 2003). Schore (2003, p. 122) says it is important to stress that the developmental attainment of an efficient self-system that can adaptively regulate various forms of arousal and psychobiological states—and thereby affect cognition and behavior—only evolves in a growth-facilitating emotional environment.

Briere and Runtz (2002) developed the inventory of altered self-capacities (IASC). They studied the impact of childhood trauma on the self-capacities of affect regulation, identity consolidation, conflict management, and idealization and found impairment with increasing early traumatic experience.

Fonagy and Target (1996, p. 217) discuss the developmental achievement of mentalization or self-reflective capacity. They say, “The integration of the dual modes into a singular reflective mode is normally completed by about the age of 4, with affect

leading cognition: the child first understands that people have different feelings, then that they may have different thoughts about the same external reality.”

The authors (Fonagy & Target, 1996) go on to say that this achievement is dependent upon experience:

In order to achieve the integration of these two modes of experience, to create fully mentalising psychic reality, the child needs repeated experience of three things: his current feelings and thoughts, these mental states represented (thought about) in the object’s mind, and the frame represented by the adult’s normally reality-oriented perspective” (p. 222).

Pollack and Slavin (1998, p. 857 ) argue that, “In classical psychoanalytic models, treatment can be understood as enabling patients to repossess their own agency—to take responsibility for themselves as agents in relation to their own motives and impulses.”

These authors also place this capacity in a developmental context.

We suggest that the attainment of the ability to experience oneself as an agent emerges from complex interpersonal and intrapsychic processes in infancy and early childhood and represents a kind of “glue” that provides the foundation for a feeling of personal coherence. We also suggest that the development of a sense of agency is predicated on the negotiation of recognition and mutual impact with parents early in life. When those negotiations go awry, the child’s capacity for agency can be disrupted (p. 857).

### *Kohut*

Kohut (1971, 1977, 1978) did not use the language of self-capacities; he did spend his life developing and articulating a theory of the development of the self through structuralization. Starting with small differentiations from Freud, his theorizing eventually led to major conceptual shifts. Kohut (1977, p. 117) contrasted his view of “psychological bedrock” to Freud’s view: “[T]he bedrock is a threat to my mind that is more serious than the threat to physical survival and to the penis and to male dominance: it is the threat of the destruction of the nuclear self.”

Kohut speaks eloquently both to what a child needs to develop a healthy self and what threatens that formation. “What creates the matrix for the development of a healthy self in a child is the self-object’s capacity to respond with proper mirroring at least some of the time; what is pathogenic is not the occasional failure of the self-object, but his or her chronic incapacity to respond appropriately which in turn is due to his or her own psychopathology in the realm of the self” (Kohut, 1977, p. 187–188). This chronic incapacity to respond properly is seen as chronic empathic failure, while “the mother’s ‘exultant response to the total child (calling him by name as she enjoys his presence and activity)’ builds the cohesive self (Kohut, 1971, p. 118).

### *Freud*

Though the term self does not arise in the literature with Freud, he does use the concept of ego, where modern psychodynamic thought often now uses the concept of self. In doing so, he manifests an understanding that the infant is born with some potential for development that is both innate and unique unto itself. “It is not our belief that a person’s libidinal interests are from the first in opposition to his *self*-preservative interests; on the contrary, the ego endeavors at every stage to remain in harmony with its sexual organization, as it is at the time and to fit itself into it” (Freud, 1963/1917, p. 351).

In fact, Bettelheim (1982) argues that important aspects of Freudian thought have been lost in translation and that the proper translation of *das Ich* is not the ego, but the I. Bettelheim (1982, p. 53) goes on to say, “To mistranslate *Ich* as ‘ego’ is to transform it into jargon that no longer conveys the personal commitment we make when we say ‘I’ or ‘me.’ More properly rendered Freud is arguing that the development of a healthy I is not

at odds with core instincts, but strives to emerge ‘in harmony’ with the instincts which precede its development.”

### *Discussion*

So what happens when the environment does not support such harmony? Where there is no exultant response from a caretaking parent? The subjects in this study talked frequently about the parents who abused them, who both actively and passively sought their psychological destruction. None of these theorists make a connection between self-capacities and pleasure. They do discuss disruption. Pollack and Slavin (1998, p. 857) have argued that parents must provide the medium from which a sense of agency arises: “[W]hen those negotiations go awry, the child’s capacity for agency can be disrupted.” Disruption of self-initiated pleasure was a topic much discussed by these subjects. Fonagy and Target (1996) are arguing that the capacity for mentalization is also dependent upon proper environmental support. Schore (2003, p. 5) sees the capacity for affect regulation as a regulatory capacity which is “experience dependent.”

In the face of overwhelming childhood trauma and neglect, these subjects convey a narrative in which the self is lost. Individually and collectively, these subjects expressed that there is little elaboration of pleasure without a self. Some of the roots of pleasure may be neurobiological. But having the innate capacity to experience pleasure is not the same as being able to elaborate this capacity. The subjects report that they do not present for therapy with a cohesive self. Two thirds of these subjects reported having a major dissociative disorder; they had multiple alternative configurations of self, none of which they experienced as having a self.

In contrast, their descriptions of therapeutic repair were consistently studied with the discovery of themselves. Finding a self was expressed as both the most pleasurable and most important outcome of psychotherapy. The corollary to the primary clinical implication of this study is that psychological growth and the development of the self are fueled by positive, often mutually pleasurable, affective engagement. This happens not when we get the interpretation right, but when we get the person right.

The patient-subjects in this study make a strong argument that the elaboration of the experience of pleasure is seated in the development and elaboration of new self-capacities for agency, affect regulation, and reflective function, which seed a sense of self. Pleasure, developing self-capacities, and “finding a self” were intermingled. Subjects did not discuss a linear developmental trajectory. Neither does the literature. Though the interface of pleasure in the development of the self is not specifically discussed, all authors are discussing self-development within a context of positive affective experience.

Can pleasure exist without a self from whom pleasure springs? Surely, one could argue that no human life exists without a self. We cannot know from this data if these burgeoning capacities are indicators of the development of an authentic self. We do know that the subjects found their selves in the context of their therapeutic relationships and this experience was imbued with pleasure.

Still, pleasure is an elusive topic. How critical pleasure was in the development of the selves of these subjects remains unknown. No one study captures this problem in its entirety. This study gives us a glimpse of the problem and the possibilities. I leave the final words to one subject. “I don’t think that any of the theories or any of the books I’ve

read really talk about this. They say stage four reorganization. I don't think that's it for somebody like me. I think its redemption. I don't even think it's *just* about pleasure. I think it's about survival. I don't think it's about finding meaning or being a better person from it, necessarily, I think it's just putting a person together, just finding out, being able to walk into the grocery store and say, what do I want? [Laughs] That would be so wonderful. To go to a restaurant and not order what the person, the other person with me is having [Laughs] To have a personality [Laughs], that would be so great. Or to recognize the one I have, you know. To have one. [Laughs] That's all I want to say."

#### A Final Note

Though this was not a neurobiological study, the literature on the neurobiology of affects was reviewed. It is worth noting that pleasure is a concept discussed within the neurobiology literature. Panksepp (2009, p. 7) says, "[I]t is a scientific fact, *and not just a conjecture*, that a series of cross-mammalian emotional systems has been revealed through animal research." Panksepp (1998, p. 182) urges the need for a scientific definition of pleasure: "a general scientific definition of the ineffable concept we call pleasure can start with the supposition that pleasure indicates something biologically *useful*." This data implies that pleasure was found psychologically useful. The resiliency of this capacity in this population makes us wonder if it might also be biologically useful.

Panksepp (2009, p. 5) further argues that his research indicates "that the raw emotional tools for feeling and living are not created by lived experiences, although they may be shaped by them." Certainly, this study implies that the patient-subject's experience of pleasure was often detrimentally shaped by his or her lived experience; pleasure was disrupted. This research also implies the possibility of an underlying

biological capacity for pleasure, which may indicate that the capacity for pleasure serves some biologically useful purpose. This deserves further study.

APPENDIX A

INDIVIDUAL CONSENT FOR PARTICIPATION IN RESEARCH

Individual Consent for Participation in Research  
Institute for Clinical Social Work

I, \_\_\_\_\_, acting for myself agree to take part in the research entitled: The role of psychotherapy in restoring or enhancing the capacity for pleasure in adult patients with reported early histories of chronic childhood abuse and/or neglect.

This work will be carried out by Janet Migdow, MA, LCPC, under the supervision of Dennis Shelby, PhD.

This work is conducted under the auspices of the Institute for Clinical Social Work, 200 N. Michigan Ave., Suite 407, Chicago, IL 60601. (312) 726-8480.

#### Purpose

The purpose of this research is to study the impact of psychotherapy on the enhancement and/or restoration of pleasure in adult survivors of chronic childhood abuse and/or neglect. Results will be used for completion of a dissertation, possible publication of articles or books, and to inform future research.

#### PROCEDURES USED IN THE STUDY AND THE DURATION

Subjects will be interviewed for up to two hours and asked to fill out one demographic instrument.

#### Benefits

No payments will be made to participants in this research. Subjects will be contributing to the accumulation of knowledge about both the effects of childhood abuse and neglect and the uses of the therapeutic process for repair and restoration.

#### Costs

There will be no costs to the subjects incurred from participation in this study.

#### Possible Risks and/or Side Effects

There are no known risks from participating in this study, but risks cannot be predicted. Subjects may have negative emotional responses and all efforts will be made to minimize this occurrence. As all patient-subjects' therapists will also be participating in this study, the researcher will require therapists to commit to availability to their patients for therapeutic support. The researcher will be available to provide additional resources as needed.

#### Privacy and Confidentiality

All instruments and interviews will be numerically coded to protect the participant's identities. Names will be changed in all written material. Information as to subject's

identities will be kept in a separate, fire proof location removed from both the interviews themselves and the written transcriptions and analysis of the data.

#### Subject Assurances

By signing this consent form, I agree to take part in this study. I have not given up any of my rights or released this institution from responsibility for carelessness.

I may cancel my consent and refuse to continue in this study at any time without penalty or loss of benefits. My relationship with the staff of the ICSW will not be affected in any way, now or in the future, if I refuse to take part, or if I begin the study and then withdraw.

If I have any questions about the research methods, I can contact Janet Migdow (773-463-1901) or Dennis Shelby, at this phone number 312-726-8480 (day), 312-458-9214 (evening).

If I have any questions about my rights — or my child's rights — as a research subject, I may contact Daniel Rosenfeld, Chair of Institutional Review Board, ICSW, 200 N. Michigan Ave., Suite 407, Chicago, IL 60601, (312) 726-8480.

#### Signatures

I have read this consent form and I agree to take part (or, to have my child take part) in this study as it is explained in this consent form.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

I certify that I have explained the research to \_\_\_\_\_ (Name of subject) and believe that they understand and that they have agreed to participate freely. I agree to answer any additional questions when they arise during the research or afterward.

\_\_\_\_\_  
Signature of Researcher

\_\_\_\_\_  
Date

APPENDIX B  
THERAPIST COVER LETTER

Janet Migdow, MA, LCPC  
Individual, Couple, Family and Group Psychotherapy  
3232 W. Victoria  
Chicago, IL 60659  
(773) 463-1901

Dear \_\_\_\_\_,

I am writing this letter to invite you to participate in my research study investigating “The role of psychotherapy in restoring or enhancing the capacity for pleasure in adult patients with reported early histories of chronic childhood abuse and/or neglect.” I am conducting this research for my doctoral dissertation at the Institute for Clinical Social Work.

I am a licensed clinical counselor in private practice in Chicago since 1977. I am co-founder and director of the Trauma Consultation Program in Evanston, Illinois, a post-graduate program in the treatment of trauma survivors founded in 1994 to enhance the skills of therapists treating some of our most vulnerable clinical populations. Additionally, I have been treating patients with dissociative disorders for over twenty years and have been awarded the status of fellow in the International Society for the Study of Trauma and Dissociation.

My research topic has evolved from the clinical work I do. I am exploring the experience of pleasure and problems related to experiencing pleasure in adults with severe early histories of abuse and/or neglect. I am interviewing clinical pairs, therapists, and their patients. Therapists will be interviewed separately from their patients. Each interview will last approximately 90 minutes and be audiotaped. I am asking each clinician to invite one current or former patient to participate in this research along with yourself. The patient invited must be someone who has been in psychotherapy with you for at least one year and whom you believe will benefit from participating in this research.

I intend this research to be an opportunity for both therapists and patients to reflect upon the both the issues of pleasure in the lives of survivors of childhood abuse and the role of psychotherapy in addressing these difficulties. To participate you need to agree to be available to your patient responsively should issues arise in the interview which require further therapeutic attention.

There are few places for therapists engaged in the treatment of these severely injured individuals to reflect upon what in the psychotherapy process they believe has meaningfully impacted the patient. This is, of course, a challenging opportunity. I understand that discussing one’s clinical work with another clinician is a vulnerable enterprise. I will make every effort to be sensitive to your needs and to pace the interview accordingly. You are free to withdraw from this study at any time. I will be available by

phone to further discuss this research and answer any questions which may arise following your interview.

All information in this study is confidential. If you agree to participate in this study, you will sign a consent form. Any identifying information will be disguised.

Please consider contacting me to discuss your participation. You may telephone me at (773) 463-1901 or email me at [jmigdow@icsw.edu](mailto:jmigdow@icsw.edu).

Sincerely,  
Janet Migdow, MA, LCPC

APPENDIX C  
PATIENT COVER LETTER

Janet Migdow, MA, LCPC  
Individual, Couple, Family and Group Psychotherapy  
3232 W. Victoria  
Chicago, IL 60659  
(773) 463-1901

Dear \_\_\_\_\_,

I am writing this letter to invite you to participate in my research study investigating “The role of psychotherapy in restoring or enhancing the capacity for pleasure in adult patients with reported early histories of chronic childhood abuse and/or neglect.” I am conducting this research for my doctoral dissertation at the Institute for Clinical Social Work.

I am a licensed clinical counselor in private practice in Chicago since 1977. I am co-founder and director of the Trauma Consultation Program in Evanston, Illinois, a post-graduate program in the treatment of trauma survivors founded in 1994 to enhance the skills of therapists treating some of our most vulnerable clinical populations. Additionally, I have been treating patients with dissociative disorders for over twenty years and have been awarded the status of fellow in the International Society for the Study of Trauma and Dissociation.

My research topic has evolved from the clinical work I do. I am exploring the experience of pleasure and problems related to experiencing pleasure in adults with severe early histories of abuse and/or neglect. I am interviewing clinical pairs, therapists, and their patients. Therapists will be interviewed separately from their patients. Each interview will last approximately 90 minutes and be audiotaped. I am asking each patient to invite your current or former therapist to participate in this research along with yourself. You must have been in psychotherapy for at least one year with this psychotherapist to participate in this research.

I intend this research to be an opportunity for both therapists and patients to reflect upon both the issues of pleasure in the lives of survivors of childhood abuse and the role of psychotherapy in addressing these difficulties. To participate you need your therapist to agree to be available to you responsively should issues arise in the interview which require further therapeutic attention.

There are few places for patients engaged in treatment to reflect upon what in the psychotherapy process they believe has meaningfully impacted them. This is, of course, a challenging opportunity. I understand that discussing one’s psychotherapy with another clinician is a vulnerable enterprise. I will make every effort to be sensitive to your needs and to pace the interview accordingly. You are free to withdraw from this study at any time. I will be available by phone to further discuss this research and answer any questions which may arise following your interview.

All information in this study is confidential. If you agree to participate in this study, you will sign a consent form. Any identifying information will be disguised.

Please consider contacting me to discuss your participation. You may telephone me at (773) 463-1901 or email me at [jmigdow@icsw.edu](mailto:jmigdow@icsw.edu).

Sincerely,  
Janet Migdow, MA, LCPC

APPENDIX D  
DEMOGRAPHIC INSTRUMENT

1. In what city, state, and country do you reside? \_\_\_\_\_
2. Your age? \_\_\_\_\_
3. Ethnic/Racial Identity? \_\_\_\_\_
4. Education: Highest degree completed? \_\_\_\_\_
5. How many siblings do you have? \_\_\_\_\_
6. Are you? (Please check one)
  1. Single, living alone \_\_\_\_\_
  2. Married \_\_\_\_\_
  3. Divorced \_\_\_\_\_
  4. Remarried \_\_\_\_\_
  5. Living with a partner \_\_\_\_\_
7. Family income? \_\_\_\_\_
8. Religious affiliation? \_\_\_\_\_
9. Number of years in current psychotherapy? \_\_\_\_\_
10. Total years in psychotherapy? \_\_\_\_\_
11. Age when you first entered psychotherapy? \_\_\_\_\_

APPENDIX E  
PATIENT INTERVIEW GUIDE

*Probes*

1. Can you describe a time in your life when you experienced pleasure?
2. How do you define pleasure?
3. What is the earliest time in your life you remember experiencing pleasure?
4. Before you attended therapy were you able to experience pleasure?
5. Since you have been in therapy, has your experience of pleasure changed? How?
6. What about therapy has made a difference?

APPENDIX F  
THERAPIST INTERVIEW GUIDE

*Probes:*

1. Can you describe a time in your patient's therapy when their experience of pleasure was discussed?
  
2. How do you define pleasure?
  
3. Was pleasure a focus of the therapy?
  
4. Do you think the patient's experience of pleasure changed over the course of the therapy? How?

APPENDIX G  
DEMOGRAPHICS

	Patients	Therapists
Age	25–70	32–75
Gender	3 Males, 12 Females	2 Males, 13 Females
Education	HS/2, AA/5, BA/5, MA/2, PhD/1	MA/12 PhD/3
Ethnicity	C/12, AA/3	C/12 M/3
Religion	N/5, C/9, 1/B	1/3 each / N,C,J
Income	\$10-140,000	\$45-600,000
Siblings	0-7	0-6
Living Status	M or P/7, S-9	M or P/12, S/4
Years in Current Therapy	2-20	
Total Years in Therapy	4-30	
Age at Entry	11-28	

#### Unanticipated Embedded Findings

	Patients	Therapists
Sexual Orientation	Bi/3 Ho/5 He/8	Ho/3 He/13

Diagnosis DID = 10 DDNOS = 5

#### Codes:

C=Caucasian, AA=African American, M=Multi-Racial  
 N=No religious affiliation, C=Christian, J=Jewish, B=Buddist  
 M=Married, P=Living with Partner, S=Single  
 Bi=Bisexual, Ho=Homosexual, He=Heterosexual

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