Taping Together Broken Bones

Treatment of the Trauma of Infant Physical and Sexual Abuse

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To explore the ways in which the particular traumas of infant physical and sexual abuse affect early development, this paper presents the long-term treatment of a child physically and sexually abused at age 4 months.

Clinical and empirical literatures are outlined and synthesized in order to elucidate the particular nature of preverbal trauma. Three specific orienting concepts from the literature that were particularly useful in the treatment of preverbal abuse are discussed: 1) Neurobiological sequelae of physical and sexual abuse in infancy and the implication of specific trauma for emotional and relational development, 2) Trauma symptoms and conceptualizations of PTSD specific to early childhood, and 3) Somatic expression and representations of trauma in child behavior and play.

Clinical conceptualization of the nature of early play, and the meaning of repetitive play observed in children who have undergone early abuse, are briefly discussed and applied to the case material. The symptoms expressed by the child and the course of the play therapy treatment are considered as ways in which to understand the somatic, behavioral, and emotional expression of the abuse.
The nature and course of preverbal trauma remain elusive. In combination with somatic and symbolic expression, verbal representation of trauma and distress has been central to the diagnosis and conceptualization of the specific impact of trauma. However, trauma occurs before there are words, preverbally and presymbolically. The particular way in which preverbal trauma affects infant neuropsychological development, including memory and affect regulation, is being explored. In addition to a developing empirical literature on the neurological theory of infant abuse and trauma, clinical material and theory have pointed to the ways in which infants and young children may implicitly and somatically “remember” trauma (Terr, 1988; Sugar, 1992; Demasio, 1994; Van der Kolk, 1994; Gaensbauer, 1995; Scheeringa et al., 1995; Schacter, 1996; Fivush, 1998; Gaensbauer, 2001; Terr, 2003).

Strikingly, infants have been observed to display symptoms similar to children and adults who have undergone trauma. However, the concept of Post-Traumatic Stress Disorder (PTSD) in infancy remains difficult to conceptualize, and even more difficult to diagnose in a developmentally sensitive manner (Scheeringa et al., 1995). Based on neurological, medical, and clinical investigation, a case has been made by clinicians and researchers alike that PTSD does occur in infancy and that traumatized infants both represent and enact the trauma (Terr, 1988; Sugar, 1992; Gaensbauer, 1995, Scheeringa et al., 1995; Ewing-Cobb et al., 1998; Gaensbauer, 2001; Terr, 2003; Isaac and Jenny, 2004).

Before language develops, the sequelae of preverbal physical and sexual abuse may begin to be represented in other ways. These may include: representation in the pre-symbolic, implicit/procedural mode, expression of dysregulated kinesic, visual/facial, emotional, and vocal behaviors, enactment of the nature of the abuse in early non-verbal play, and presence of maladaptive attachment and relational patterns in infancy and early childhood.

The assessment of infant neurological and psychosocial development is essential to developing conceptualizations of infant PTSD. Preverbal difficulties with self-regulation, evidenced by destabilized somatic and behavioral states, may point to specific risk factors for developing affective regulation difficulties, relational difficulties and insecure attachment, and possible subsequent child psychopathology. The exploration of memory expressed nonverbally or in a fragmentary verbal fashion is also valuable as a way of understanding the nature of the trauma and the child’s experience (Fivush, 1998). Further exploration of the sequelae of preverbal trauma may result in empirical outcome measures that allow earlier assessment of
risk, more developmentally grounded, clinically useful diagnosis, and more sensitive methods of early intervention and ongoing clinical treatment.

To explore the ways in which the particular traumas of physical and sexual abuse affect early development, this paper will review the literature on:
1) Neurological sequelae of pre-verbal physical and sexual abuse in infancy, and the implication of specific trauma for emotional and relational development,
2) Trauma symptoms and conceptualizations of PTSD specific to early childhood,
3) Somatic expression and representations of trauma in child behavior and play.

To illustrate the expression of symptoms specific to physical and sexual abuse in infancy, and to form a more vivid clinical picture of the somatic, cognitive, emotional, and relational sequelae of preverbal abuse, the case of a child severely physically and sexually abused at four months will be described. The treatment case presented will focus on ways of understanding the infant’s internal and relational representations of distress by way of the young child’s nonverbal communication and early symbolic play within a long-term treatment.

**Infant Trauma: Introduction**

As conceptualizations of cognitive, emotional, and relational capacities in infancy shift with an ever-increasing contemporary focus on infant research and primary prevention, the concept of infant trauma and its effect on child development is beginning to be explored. Several related bodies of empirical literature on normal infant development are useful in providing a background to theories of the impact of early abuse and trauma (Markese, 2007b). The current paper will focus on neurological, somatic, and emotional sequelae of physical and sexual abuse in the preverbal period.

Research on the impact of trauma in infancy, prior to the onset of language, remains relatively sparse (Perry, 1994a; Perry, 1996). Diagnosis of infantile abuse may often be delayed due to the potential lack of observable physical symptoms, especially common to “non-impact trauma” such as physical shaking and some forms of sexual maltreatment (Ewing-Cobbs et al., 1998). The sequelae of infant abuse are difficult to investigate due to a lack of useable research and diagnostic tools that reflect the experience of the trauma in infancy (Ewing-Cobbs et al., 1998; Sheeringa et al., 1994). However, important developments have been revealed as research is beginning to assess the neurological trauma of “inflicted traumatic brain injury,”
or clinically termed “shaken baby syndrome,” using neuro-imaging to elucidate brain injury specific to abuse in infancy (Ewings-Cobb et al., 1998). Neurobiological models of infant development provide important clues as to the ways in which infants process the traumas of physical and sexual abuse, as well as how brain injury affects ongoing development. Additionally, limited but compelling clinical evidence suggests that specific abuse is in fact remembered and represented preverbally. By reviewing these literatures, a picture of early, preverbal symptoms of PTSD particular to infants is revealed.

**Neurological Sequelae of Traumatic Brain Injury Secondary to Infant Abuse**

Neurodevelopmental sequelae specific to abuse in infancy have been documented. Researchers have begun to identify specific regions of the immature brain that are affected by early maltreatment. The early experience of trauma has been shown to result in neurobiological brain abnormalities, including dysfunction in the regulation of the pituitary–adrenal axis, the locus coeruleus, and the ventral tegmental nucleus, and subsequently impoverished regulation of the stress response (Weller et al., 1988; Perry, 1996; Schore, 2002; Schacter, 1996).

Further, specific neurological and physical sequelae of traumatic brain injury as a result of early abuse include cerebral atrophy, reduced hippocampal volume (specifically left hemisphere reduction), hippocampal damage due to excessive exposure to stress-related hormones or glucocorticoids, and retinal hemorrhage (Bremner, 2000; Ewing-Cobbs et al., 1998; Isaac and Jenny, 2004; Schacter, 1996). Brain abnormalities may indicate compromised functioning of neurotransmitter receptors. In terms of consequences, reduced serotonergic activity in the brain has been associated with disorders of impulsive aggression, while increased responsivity of cholinergic systems has been related to affective instability (Skodol et al., 2002).

As a result of abandonment, severe neglect, and maltreatment in the first year of life, significantly debilitated cortical functioning of the fronto-temporal areas of the developing brain has been discovered (Chugani et al., 2001). Researchers have implicated these same brain regions independently in the ability to infer mental states and to achieve developed reflective functioning capacities (Frith, 1996).

The compromised development of right brain structures has also been advanced as a specific consequence of abuse and trauma in infancy.
Damage to these brain structures has been linked to the presence of dissociative symptoms and disorders of aggression (Schore, 2002). Additionally, excessive pruning of neuronal pathways in the infant brain as a result of early trauma may result in difficulties regulating negative emotions, and especially states of fear and anxiety (Schore, 2002).

It has been widely documented that early abuse is linked to infant disorganized attachment, which is in turn associated with chronically elevated cortisol release during separations and slowed return to resting levels (Spangler and Grossman, 1993). Heightened resting cortisol levels secondary to trauma indicate chronic states of dysregulation, potentially compromised neurodevelopment, and a resultant risk for impaired self-regulation and relational and self-regulatory capacities (Ewing-Cobb et al., 1998).

Neurobiological research has demonstrated that early trauma impacts directly on the infant’s developing capacity to process, interpret, and regulate emotions (Devinsky, 2000; Schore, 2002). States of hyperarousal or dissociation resulting from early trauma both organize the neurodevelopment of the infant and leave the infant sensitive to future traumatic reactions. Consequences of this early vulnerability include the impaired capacity to regulate affect and somatic state, and to represent and integrate aspects of the self.

**Post-Traumatic Stress Disorder in Infancy and Early Childhood**

The synthesis of clinical and empirical literature brings the symptom picture of a traumatized, abused infant to light. Similar to children and adults, infants have also been shown to have PTSD-like symptoms following exposure to traumatic events, and lasting years after the initial traumatic experience. As in childhood, stress responses to separation are especially pronounced following trauma in infancy (Gaensbauer, 1995). Re-experiencing of the trauma and intrusive thoughts are also evident in young children following trauma in infancy, and are often enacted in behavior or in early symbolic play (Terr, 1988; Gaensbauer, 1995).

Physiological symptoms similar to adult PTSD are present in infants, and take the form of both difficulties in the regulation of biological and physiological rhythms and an increased preoccupation with self-regulation. The enactment of bodily experiences linked to the trauma has been observed as an acute reaction to stress occurring over the course of the child’s development (Gaensbauer, 2002). Both behavioral and emotional
problems have been observed in abused infants, including labile states of mood and attention, excessive distress, and agitation (Gaensbauer, 2004).

Children’s reactions to injury and abuse are specific, yet span a range of symptoms, including behavioral and conduct disorders, anxiety disorders, depressive disorders, and disorders of attachment (Kranzler et al., 1990; Schwartz & Perry, 1994). A symptom picture particular to abused infants and preverbal children is demonstrated in a high incidence of separation anxiety and regressive attachment behavior, and the manifestation of overt, anxious attachment behaviors in response to normal separations (Kranzler et al., 1990).

Although infants and toddlers who have experienced abuse cannot verbally report their experience, both repetitive play about the trauma and the inhibition of all play have been reported. Abused and traumatized children exhibit obsessive reenactment of the trauma in play and behavior, which may indicate the presence of intrusive thoughts and memories. In contrast, the inhibition of symbolic play and affective expression may indicate avoidance of triggers for the trauma (Pynoos, 1992).

Parallel to the dual states of PTSD described in the adult literature, both hyperarousal and dissociation have been described as symptoms of abuse in infants and young children (Pynoos, 1992). These opposing neuronal patterns take a different form in childhood. Hyperarousal is characterized by aggressive behavioral acts and emotional displays, and dissociation associated with inhibited emotional reactions and symbolic capacities. Both responses may give the appearance that the child is unfeeling or unconcerned about the traumatic events (Pynoos et al., 1987; Perry, 1996). As a result, neurobiological reactions to trauma in early childhood are often misconstrued as defiance or as a lack of emotion, when in fact these behaviors signal a high level of distress and anxiety. These behavioral differences from adult PTSD contribute to enduring misconceptions about the presence and nature of distress in children.

Models of PTSD in infancy and early childhood advance a neurological underpinning for symptoms of early abuse. Exploration of resulting damage to specific brain structures provides a map for the ongoing risk for maladaptive development subsequent to abuse in infancy. Because these neurological responses to trauma organize the child’s developing neural systems, children are particularly susceptible to the lasting effects of trauma on personality and psychosocial development (Perry, 1996). As the initially adaptive hyperarousal/dissociation trauma response of the central nervous system organizes early brain development, maladaptive neural pathways
are activated and selected, resulting in a priming of dysregulated states, leaving the child vulnerable to dissociation and future disorders of attention and mood.

Somatic Expression and Representation of the Trauma of Abuse

A clinical and empirical debate exists as to the nature of the infant’s capacity to represent abuse prior to the development of language skills. Some theory and research suggests that representations exist only in the child’s visual/motor memory, and are only accessible through somatic/behavioral enactment. Other work offers compelling clinical evidence that early memories of trauma and abuse may be symbolically and verbally represented and expressed as children develop (Gaensbauer, 1995, 2002, 2004, 2005).

When provided with the means to represent and reenact traumatic experiences, children who had undergone diverse traumas between the ages of 6 and 15 months were able to convey accurate sensory and somatic details of the trauma, both behaviorally and verbally (Gaensbauer, 1995). Representation and enactment of the trauma through symbolic play allowed the children to express and to verbalize their experience. Such material presents the possibility that preverbal trauma can be reorganized and rerepresented as development takes place, shedding light on connections between infantile behavioral, sensory, and emotional memories, and their more symbolically enacted and verbally represented forms in later childhood.

Regulation and dysregulation of somatic states serve as clues into the infant’s experience and representation of early preverbal experience. Before there is language, there is the language of the body, which speaks in terms of “somatic markers,” affective states experienced internally on a continuum from hypo- to hyper-arousal, (Demasio, 1994). This view emphasizes the centrality of body and brain in informing emotions, memories, and representations. The self is a “self distributed through the body,” and it “represents the outside world in terms of modifications it causes in the body proper,” (Demasio, 1994, p. 230). As van der Kolk (1994) describes, before there are words, and especially in overwhelming traumatic states, “the body keeps the score.”

Studies have shown that infant memory is functional preverbally, as early as two to four months, and that these early memory traces continue to
mediate long-term memory and behavior even as the infant’s symbolic capacities develop (Davidson and Fox, 1982; Daehler and Greco, 1985; Rovee-Collier and Hayne, 1987; Perris et al., 1990; Rovee-Collier, 1997). Early pre-symbolic memories, and especially those of trauma, may be re-experienced in later stages of development as sudden and uncontrollable experiences of bodily dysregulation (Schore, 2002), as somatosensory experiences (van der Kolk, 1994), or as implicit, unidentifiable “emotional memories” (LeDoux, 1995). These intensely felt, but perhaps symbolically indescribable, somatosensory memories may underlie some of the experience of the inner turmoil of PTSD, as well as being at the root of the experience of uncontrollable, unpredictable affect storms.

Early disturbances in the infant’s self- and interactive regulation of kinesic, visual/facial, emotional, and vocal behaviors have been shown to indicate current and future emotional and relational disturbances (Lyons-Ruth, 1998; Jaffe et al., 2001; Markese, 2007a). Dysregulation of somatic and affective states in infancy has been widely associated with maladaptive attachment and relational patterns in early childhood and across development. Trauma derails the infant’s ability to regulate self and interactive states, thus placing these children at risk for engaging and being engaged with in non-optimal relational patterns.

The Role of Play in the Treatment of Early Abuse

The aspects of children’s play which recreate and repeat unpleasurable experiences have long been recognized in the psychoanalytic literature. Freud (1920) described the game of “gone” played by a 1½-year-old boy in some variation with all of his toys. The boy’s game usually focused on the disappearance of objects, and only occasionally ended in the reunion in which Freud theorized the boy found pleasure. The “gone” phase of the game served the child as he expressed his anger towards the abandoning parents. The repetition allowed the child to be an active agent in the separation, rather than a passive recipient of actions that could not be controlled. Thus, the play allowed the child to work towards mastery of feared, uncontrollable experiences (Freud, 1920).

Vygotsky (1933) further described the role of play in early childhood, also emphasizing that the central purpose of play is not direct pleasure, but the working through of concepts that allow children to develop cognitively, socially, and emotionally. Play is “not symbolic action in the proper sense of
the term” (1933, p. 92), meaning that the actions of a child’s play do not directly correspond to the child’s inner world. Rather the process of playing points at the child’s processing of inner and external experience.

In early forms of play, children begin by creating imaginary situations that are intimately tied to real experience (Vygotsky, 1933). In this conception, preverbal play has been understood as “more nearly a recollection of something that has actually happened than imagination….It is more memory in action than a novel imaginary situation” (Vygotsky, 1933, p. 103). This has been previously described clinically, specifically in cases of early trauma, in which the child’s play functions as a form of retelling the story of the trauma (Terr, 1988; Sugar, 1992; Gaensbauer, 1995, 2002; Terr, 2003; Gaensbauer, 2004, 2005).

In these ways, early play and play that retells the story of an early trauma contain important regulatory aspects. Play allows the young child to use action and affect to represent and bind past experiences and the attached thoughts and emotions, which may be both complex and frightening. Much in the same way that language is used as the child gains access to more developed receptive and expressive symbolic capacities, the play of trauma allows the child to represent and express the abuse.

Case Description

Play therapy, in combination with supportive parent work, was the central method of treatment in the case of preverbal physical and sexual abuse to be described. Parent sessions were oriented towards helping the adoptive mother (from the time of the trauma, age four months) understand the child’s behavioral and emotional difficulties in light of the injuries and trauma she had sustained in infancy. Although her mother repeatedly voiced the impossibility that her child could remember the trauma, she worked towards an eventual awareness that she had “somehow been affected.”

In addition to the regulatory aspect of play previously described, play in a therapeutic context privileges the importance of early relationships as part of the developing symbolic and representational world of the child. Expressive play in the context of an attuned relationship seeks to set the trajectory for optimal later development. Of central importance to the treatment of early abuse, play therapy both allows for the child’s expression of aggressive, angry affect which may be discouraged in home and school settings, and
helps the child to identify and contain these intense affect states while creating a narrative of the child’s experience.

Laura was four months old when she was discovered by a family friend, unresponsive in her crib, in the biological home from which she was permanently removed. The unthinkable was discovered as she was admitted to the hospital. She had sustained numerous fractures, including the “long bone” femur fractures particular to Intentional Traumatic Brain Injury (TBI), or “shaken baby syndrome” (Ewing-Cobbs et al., 1998). Additionally, unique to TBI, she had retinal hemorrhaging and signs of cerebral trauma, including lack of response and lethargy. This unimaginable level of physical and cerebral damage was compounded by the discovery that Laura had been sexually penetrated by her abuser. Further examination revealed that her internal sexual/reproductive organs were severely damaged, requiring numerous gynecological surgeries in infancy and invasive examinations throughout her early years.

Laura was brought into treatment at age three and a half by her mother, at the referral of her early-intervention teachers who described an array of disturbing behavioral symptoms. Laura barely spoke in school, and when she did, she either whispered or almost yelled short phrases in an unmodulated voice. She paced around the class, had no interactions with peers, and constantly wrung her hands, scratched and bit herself, and collapsed into uncontrollable crying fits with no apparent cause. At home, her mother described uncontrollable eating binges followed by vomiting, nightmares and general insomnia, and periods in which she appeared dissociated and glazed.

Laura presented as a slight, pale, hypervigilant girl, staring anxiously from behind her glasses. Despite her vigilance, Laura did not hesitate to enter the play room. She was silent as she began systematically searching the room, tearing open closets and drawers with a force beyond what would be expected by her physical persona. She did not once investigate the toy shelf, ignoring a large enticing doll house and stuffed animals. Finally, she discovered a battery-operated police car and moved directly to pressured play, roughly taking it apart and putting it back together. She examined the battery compartment, which was empty, and went back to her search of the room. She turned up several mismatched batteries and spent the rest of the session shoving the batteries into the car. She did not make eye contact or acknowledge the narrative that accompanied her play, that she was trying so hard to fix the car and to make it work. This, of course, seemed impossible given that the correct batteries were not in the office. Amazingly, with a set of mismatched batteries, she managed to make the police car siren
sound. She made eye contact briefly, shouted “I make it wurkd!” and then roughly threw down the car and ran from the room.

Throughout the next eight months of play therapy, Laura continued to play in ways similar to her play with the police car in the first session. She was preoccupied with all mechanical objects and objects with working parts, such as hole punches, calculators, and other office supplies. The only toys she played with were trucks and cars, games with assembly required, and toys with interconnecting pieces. Her play was perseverative and rigid. She would choose an object, roughly take it apart, and attempt to reconstruct it. She appeared to ignore all narrative commentary and remained silently disconnected from the therapist.

As she was gently introduced to more creative toys and outlets to express herself, Laura became interested in drawing pictures. Again, her movements were rough and lacked control, and her drawing had a frantic, pressured quality. Her drawings themselves were quite disturbing and primitive for a 4-year-old child. She drew herself, her mother, and the therapist in different configurations. The faces had only chaotically placed, large gaping eyes. Often, the figures resembled skeletons, with protruding arms and legs and large billowy wings, which Laura labeled as dresses. In her many previous searches of the office drawers, Laura had discovered scissors and tape. She became obsessed with drawing the figures, stabbing at them repeatedly with markers and then “cuk” ing them apart. At this point, she became more interested in the therapist’s comments, such as “Oh no, they are getting cut apart. What happened? What can we do?” and more engaged in general. She began to ask for help in taping the figures back together, and a therapeutic process began.

Laura became interested in the story of the people, what had happened to them, and how they could be put back together. When it was suggested that they could have a safe place on the wall of the playroom, Laura was very excited. She spent the last part of each session diligently taping every possible edge of her pictures to the wall. She took immense pleasure in this ending ritual, and a version of the therapist’s words, “They are put back together now, and they can be safe, right here, until you come back.” In her home and school life, Laura had become far less agitated, and she had been able to better regulate her bodily states of hunger and sleep and her emotional states of extreme distress and anxiety.

In her 4-year-old year of preschool, Laura began to express more anger and some passive oppositional behavior, generally silent refusal, when she was uncomfortable or fearful, such as in less structured social situations. Her social skills had improved only slightly, and she remained delayed in
motor development and in her receptive and expressive language capabilities. She continued to receive speech therapy and occupational and physical therapy in school.

In the second eight months of treatment, overall, Laura had become much more verbal and interactive, speaking more directly to the therapist and expressing and acknowledging a slightly wider range of emotions. Her play, however, remained in the repetitive, non-elaborated range. She herself did not elaborate on her play theme of deconstructing and repairing, although she responded to the narration of these themes in her play by the therapist. Laura still had difficulty labeling affects, and often could not tolerate any affective interpretation within the play. When she became frustrated, upset, or overwhelmed, she appeared glazed and dissociated. At other times, she would begin to systematically empty all the toys on the floor and throw them across the room in a flat, yet disorganized and uncontrollable manner, eventually crying and appearing sad and apologetic.

Despite the intensity and the destructive nature of her rage states, she was helped by attempts to calm and contain her anger and distress. She eventually responded to the therapist’s vocalizations of her upset and gentle support of her, calming down through sitting on the floor close together and breathing in and out slowly. She appeared relieved by the repair of helping to “clean up,” singing to herself in order to self-regulate as she helped to pick up the toys.

A year and a half into the therapy, Laura became visibly more disorganized, dissociated, and dysregulated. These observations were echoed in reports from her mother and from the school. In a parenting session, her mother realized there were environmental changes that might be contributing to Laura’s distress. There had been talk about the family moving within the building, although she had not thought Laura was aware of it. She also wondered if Laura was becoming anxious about the impending school change to kindergarten.

At first, Laura’s behavior seemed to be oppositional and defiant, but not pathological. She reportedly ran out of the classroom several times a day, laughing and running through the hallways. While her behavior did not seem immediately linked to her history of trauma, it soon escalated, becoming highly aggressive and dangerous. Laura’s extreme distress became apparent, as did her inability to control her states of aggression and dysregulation. Although frail, when distressed, Laura was unnaturally strong. During her behavioral episodes, she took large pieces of furniture
and play equipment and shook them violently with a flat expression. She began tearing at her own hair, attempting to cut herself with scissors, shov- ing non-edible objects in her mouth, howling, spitting, hissing, and biting at her own arms. She quickly moved from hurting herself to kicking and hitting anyone around her.

There was a manic, pressured quality to her movements. She was observed laughing and rolling on the ground frequently without the ability to regain control. At times that were too physically under- or overstimulating, such as nap time, bathroom breaks, and physical education, she would crawl around on the ground, hide under things and weep. At these times, she was unable to tolerate any physical or social contact and would find the smallest space possible to crawl into, folding her arms around her head and legs. As her episodes continued to grow more disturbing, Laura had to be hospitalized briefly and continued to be medicated following to calm her intense affects, regulate her insomnia, and help her to control her anxiety and aggressive, dysregulated behavior.

As the seriousness of Laura’s symptoms came to light, so did the horrifically violent and chaotic circumstances of her early months of infancy. Laura’s expression of PTSD symptoms, secondary to the abuse she endured in infancy, provided vivid clinical evidence; the dissociation, hyperarousal, aggression, and self-destructive attempts to control her body and mind.

As Laura became more stable, her mother was more able to think about her experience, advancing a theory as to why Laura had experienced and conveyed such dramatic dysregulation. Although the move had not taken place, changes in the building had forced the family to give up their pet. It had never been discussed, but Laura, who had severe disturbances in her sleep, often slept with the family pet, and had since she was very young. The stress of not sleeping, along with the trauma of the loss of a companion, a central attachment object, so essential to her self-regulation, seemed to have been a powerful catalyst for Laura’s revisiting of her preverbal, chaotic, and violent early experiences.

As Laura began to recover following her hospitalization, two years into the treatment, a new theme emerged in her play therapy sessions. She continued to draw pictures very similar to those she had done earlier, largely primitive representations of chaotic figures, usually herself, her mother, and the therapist. Although she now worked hard to “decorate” the figures, with every sticker, staple, and paint splotch that she could inflict, there was an undeniably sad and injured quality in the drawings and in her play. She appeared drained and confused, seemingly unsure what her mind and body...
might signal. After finishing, she often slumped in a chair, appearing hopeless and defeated.

Each session, Laura asked for paper and art supplies, and each time, she repetitively drew the familiar figures she had since age three: mommy, herself and the therapist, skeletal with faint outlines representing “princess dresses.” It had become clear that Laura felt a drive to repeat the drawings, yet felt disconnected from her self, others, and the world. When asked, “What could we do to make the people safe, to make a place for them?” Laura returned to rifling through the familiar office drawers. Presented with an envelope by the therapist, Laura responded with relief. She asked for help to address one to mom, one to the therapist, and one to herself, placing the drawings inside and sealing them, with one for each to keep. In a remarkable act of resilience and healing, Laura moved towards symbolizing an aspect of the conflict central to her trauma, that of the competing drives she experienced for intimacy and self-preservation.

In light of the literature reviewed, Laura clearly suffered from traumatic brain injury and neurological impairment consistent with the extremely severe preverbal physical and sexual abuse she endured. Laura’s intensely felt, but largely symbolically indescribable, somatosensory memories often left her in a state of inner turmoil characteristic of early PTSD. Although Laura was resilient in many ways, she continued to struggle mightily throughout her infancy, early childhood, and school years to regulate her body, to regulate her emotions, and to represent her internal experiences and affects.

Triggered by the loss of an important attachment and self-regulatory object, Laura became vulnerable to reexperiencing bodily and emotional states connected to her preverbal trauma. It seemed that her behavioral enactment of violent shaking, self-harm, and chaotic movement were in fact the expression of unregulated early “action memories,” or implicit, unidentifiable “emotional memories” (LeDoux, 1995), reexperienced as the sudden and uncontrollable bodily dysregulation described by researchers, theorists, and clinicians (Gaensbauer, 1995, 2002, 2004; Schore, 2002; van der Kolk, 1994). Her symptoms were synonymous with those described in the childhood PTSD literature. Bodily, somatic experiences linked to the trauma seemed to reemerge in her behaviors as an acute reaction to the stress of separation and loss (Gaensbauer, 1995, 2002).

Play therapy allowed Laura a space to express her uncontainable, unpredictable affects, and the beginning of a narrative of her early experience. As Laura became better able to tolerate and comprehend her states of hypo- and hyper-arousal and intense negative affect within the therapeutic envi-
ronment, she was helped to find creative ways of expressing her distress; creating, destroying, repairing, elaborating, and finally making a safe space for the self and the relationships that she worried about. Although the early traumas of physical and sexual abuse compromised Laura’s cognitive, emotional and relational development in powerful ways, she demonstrated an amazing capacity for resilience and a determination to form relationships and to make things which had been badly broken work again.

Summary

Longitudinal assessment of children following preverbal trauma has documented an increase in overall psychopathology as a result. Studies document an increase in a wide range of affective disorders, specifically depression and anxiety disorders and PTSD extending through childhood into adulthood (Clayton, Desmarais, and Winokur, 1968; Harris, Brown, and Bifulco, 1986; Weller et al., 1988; Kranzler et al., 1990; Garber, 1997; Yehuda et al., 2001). Empirical and clinical case materials illustrate the impact of trauma on neurological and emotional development (Gaensbauer, 1995; Scheeringa et al., 1995; Ewing-Cobb et al., 1998; Isaac & Jenny, 2004). Taken together, compelling evidence exists that preverbal trauma both compromises early development, and sets the course for more maladaptive patterns of self regulation and relatedness as children mature.

Young children who have been abused exhibit an increase in aggressive, externalizing behavior, as well as an inhibition of expressive communication and symbolic play (Pynoos, 1992). Both inhibition and externalization of affect related to early abuse and trauma have been shown to impede the child’s healing process, with ongoing developmental consequences (Toth and Cicchetti, 1998).

Importantly, researchers have documented that abused and traumatized children who have been given the chance to express their emotions in play and family therapy are less likely to exhibit behavioral and emotional disturbances as development progresses (Kranzler et al., 1990). Play therapy that recognizes the role of trauma and abuse in infancy in organizing the child’s internal and relational world provides a space for the expression of the intense aggression and negative affect states that are central to the abused child’s story. The therapeutic relationship is essential as it allows the child to begin to represent and modulate painful affects associated with the trauma, and to embark on the difficult healing process.
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REFERENCES


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