Chapter Sixteen

Games Psychotherapists Play

Hide-and-Seek in the Therapeutic Dialogue

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INTRODUCTION

Play suffuses the brains, bodies, feelings, and minds of mammals—humans included—in service of the open neural wiring that allows postnatal experience to shape behavior. Because play is so basic, we also naturally find play present in the diverging psychoanalytic, Jungian, Gestalt, and even cognitive-behavioral approaches to treatment. In fact, as an affiliate and ally of the therapeutic dialogue, play emerges spontaneously and intuitively across all psychotherapeutic modalities.

Clinicians may sense the urge to play coming to the fore as they deliberately search for new possibilities. For example, some therapists will use play explicitly as a tool, with children at sand tables. However, during psychotherapy, play most often emerges from subcortical roots beneath the conscious awareness of participants, where it operates *at implicit levels* (Marks-Tarlow, 2012a, 2012b).

Though unspoken and often unacknowledged in therapy with adults, adolescents, and couples, play helps to structure what Donald Winnicott, the twentieth-century British pediatrician and psychoanalyst, called *intersubjective space*. Through play, in this *space between*, therapists and patients negotiate rules of emotional engagement. They establish patterns of turn-taking and rules of interpersonal coordination. They explore when and how to seek intimacy. They also discover when and how to disengage from close contact.

The games that emerge during psychotherapy tend to morph along with changing levels of safety and trust. Both patients and therapists will ask "Should I come forward or hide?" and "Is it safe to reveal vulnerable feelings and deeper layers of self or better to conceal them?" Because answering those questions proves crucial to healing, I end this chapter about the role of play in therapy with a call for psychotherapists to pay closer attention to implicit games as they arise during psychotherapy. When psychotherapists elevate unconscious relational exchanges to conscious awareness, when they seek to understand not just their patients, but also the rules of the games that regulate interactions implicitly, they enhance the capacity for mutuality and co-creation and hasten healing as well.

DEVELOPMENTAL NEUROBIOLOGY

The essence of psychotherapy involves engaging in a caring, attuned relationship geared toward healing emotional traumas from the past that deprive people of their full repertoire of feeling states and make it difficult to withstand the intensity of intimate contact. While different kinds of psychotherapy focus more or less on unconscious aspects, most forms interested in deep, embodied change aim to grow a healthy sense of self capable of open and fulfilling participation in love and work. Here patient and therapist are like co-gardeners, where one of the gardeners is also the plant. During psychotherapy, as during development, a healthy self will only set down roots and flower in the intersubjective soil of secure attachment (Bowlby, 1969; Greenberg, Cicchetti, & Cummings, 1990).

From birth onward, babies need to be touched, cuddled, played with, doted on, worried over, gazed at, worshipped, sung to, meditated on, fantasized about, apologized to, and showered with every nuance of emotion. These affective ingredients are as vital as air, food, and water in order for children to mature feeling internally safe and externally resilient. John Bowlby, a British psychiatrist and psychoanalyst, proved with his attachment theory (1969, 1973) that babies instinctively seek a secure emotional bond with primary caregivers. The securely attached baby, making up roughly 65% of the population (Prior & Glaser, 2006), responds optimally to a mother's steady availability, emotional understanding, and fully responsive involvement. A safe and secure baby is free to openly explore the environment and to play in his or her mother's presence.

The more contemporary field of regulation theory dips underneath attachment behaviors to track changes in the autonomic and central nervous systems as caretaking and play occur. Allan Schore, a clinical psychologist and neuropsychologist, developed regulation theory (1994, 1997, 2012) in order to link human bonding tendencies with their physiological underpinnings in the brain and body.

According to Schore, after birth the quantity and quality of ongoing interactions between caregivers and infants during periods of critical development shape cell growth, determine patterns of neural connectivity, and reduce neural connections as complexity builds (Marks-Tarlow, 2008; Siegel, 1999). The precise nature of early interactions supplies the physiological foundation for the self-organized emergence of different qualities of mind and various states of health or pathology, both in body and mind.

When caregivers intuit babies' emotions, match their levels of arousal, and move in sync with their needs, they increase the chances of happy and securely attached babies. When caregivers miss the mark, either by misunderstanding babies' cures or purposely ignoring them, the results can be disastrous, leading to anxious, avoidant, or disorganized forms of insecure attachment that set the stage for later psychiatric and medical conditions (Schore, 1997).

The importance of secure attachment to building healthy brains and bodies is not restricted to human babies. Beginning with the work of Darwin (1872) and continuing through studies by Paul Ekman (2003), researchers interested in the neurobiology of emotion have broadened their scope of examination to include different animal species within an evolutionary context. Jaak Panksepp, founder of the field of affective neuroscience, is a neuroscientist who studies ethology, or the comparative science of animals' behavior and "character," specializing in affective development.

Panksepp (1998) has identified seven discrete emotional circuits that are common among all mammals: seeking, care, lust, play, panic, rage, and fear. Each circuit has distinct neural and neurochemical architecture to link sensory, affective, motivational, and behavioral areas of the brain. Each circuit originates in lower reptilian, subcortical centers of the brainstem,

extending through middle-level, limbic mammalian areas, and winding up in the highest, cortical areas associated with uniquely human expression and culture.

Of the seven circuits, two main sets of social instincts—care of the young and the tendency to play—separate the open wiring (shaped by postnatal learning) of the mammalian brain from the closed wiring (preset by genetics) of the reptilian brain. First, the care circuit constitutes the primary drive to protect, care for, love, and nurture babies. In many species of mammals, the care circuit extends to bonding with a particular mate to create a parental unit. These social and behavioral instincts are what drive us humans to *care for* babies until they reach maturity, while emotionally *caring about what happens* throughout life. The anthropologist Helen Fisher (1994) speculates that, among humans across various cultures, romantic love drives people to attach to a single mate in order to co-parent offspring, while lust drives people in the opposite direction to cheat with multiple partners in order to spread genetic seeds more widely.

Interpersonal neurobiologists as well as attachment theorists have noted that during early postnatal development, the attuned caretaker is devoted to reading and responding to baby's emotional states and physical needs. Through attuned responding, caretakers read the motivation, understand the emotions, and match the arousal levels of their babies (Beebe & Sloate, 1982; Schore, 1994).

Yet despite the best of intentions and however much attention is invested, small ruptures in safety and trust in the fabric of the relationship inevitably occur. Ruptures occur whenever a caregiver "misses" emotionally. Rupture and repair serves as the first interpersonal pillar for baby's self-development. Through a series of small ruptures and repairs, the bonds between parent and child slowly strengthen. Meanwhile, hope is instilled that even if negative experiences should arise, they can be transmuted toward positive directions.

Because ruptures lend an opportunity to repair the relationship, Winnicott's (1971) "good-enough" mother is even better than a perfect one. Perhaps father fails to notice a child's fearful expression or mother doesn't change a dirty diaper in time to avoid physical discomfort. Whenever a rupture occurs, no matter how young the baby, it is crucial for the caregiver to recognize and communicate about the oversight, by displaying empathy plus the willingness to address what was overlooked before. This is how trust, resilience, and secure attachment build in the relationship.

That said, importantly, attending to ruptures does *not* always equate to fulfilling needs or gratifying emotions.

It is interesting to note that embedded within animal play, the second main circuit that separates mammals from reptiles, researchers (Bekoff, 2004; Bekoff & Pierce, 2009) have also identified a rupture and repair sequence, especially for canine species that live in packs. Within rough and tumble play, if an animal bites too hard or plays too rough, all play ceases. An apology must be offered in the form of a play bow, much like that which ritually ushers in play to begin with. Only after the apology has been accepted can play recommence. However, if the errant animal continues to violate the trust of the pack through repeated offences, eventually it will be ousted from the pack.

Studies reveal that loners forced to live outside the pack are far more likely to die. This underscores how much, even in the animal world, play is serious business, with life and death significance attached to play's socializing functions. Bekoff calls this "justice"—which course doesn't prevent a primus inter pares from emerging.

INTERPERSONAL NEUROBIOLOGY OF PLAY

Whereas the young of animals are most likely to play with their cohorts, human children initially play with their parents and only later graduate into play with cohorts. In human parents, the spirit of play blends seamlessly with the care circuit, while in children the spirit of play blends seamlessly with the developing self-system plus the child's capacity to orient and navigate in social space (Marks-Tarlow, 2010, 2012a). Social play serves both to stimulate and to soothe, as it expands a baby's regulatory window of affect tolerance (Fosha, Siegel & Solomon, 2009).

Most primitively, play entrains, that is, brings into sync, physiological systems in mother and child, along with their underlying brain waves (Marks-Tarlow, 2010; VanderVen, 1998). We easily understand how a mother's and a baby's internal systems become naturally coupled in the womb. Their hearts, brains, digestive systems, and even interior worlds are initially linked through the placenta, such that the mother's internal rhythms automatically regulate the baby's body. Yet after birth, a baby still relies on its mother for emotional regulation and even regulation of physiological processes, such as sleep-wake cycles and digestion. By adding the whole body's gross and fine motor system into the mix, early play enables the complex coordination of interpersonal rhythms based on safety, trust, escalating arousal, and full engagement in positive emotional states.

Early dyadic play promotes mutual immersion in Stern's (1985) "vitality affects" of excitement, joy, interest, desire, and curiosity. These are the experiences that grant us energy, enthusiasm, and our very sense of aliveness throughout our lives. Whereas negative emotions narrow people's perspectives, often leading to contraction of social horizons and withdrawal, positive emotions expand people's perspectives, while broadening their repertoire of thoughts and actions (Frederickson, 1998, 2001). Because it is inherently fun and self-reinforcing, play enhances the intrinsic motivation to engage in activities for their own sake, that is, for the pleasurable, enjoyable, and/or absorbing experience of the process, rather than as a means to outside ends.

Most of babies' early play is social, unwittingly staged within Vygotsky's zone of proximal development (1978), where new mastery is likely. Neurobiological, psychological, sociological, and anthropological researchers have identified a host of affective, cognitive, social, and motor capacities that accompany children's play (for a summary, see Marks-Tarlow, 2010). These include self-regulation (Berk, Mann, & Ogan, 2006; Vygotsky, 1986); symbolic representation (Piaget, 1962); narrative skills (Nicolopoulou, 2005); meaning-making (Bruner, 1990); divergent thinking (Baer, 1993); creative expression (Singer & Singer, 1998); self-transformation (Garvey, 1977; Schwartzman, 1978); metacommunication (Bateson, 1976); gender identification (Davies, 1997); social competence (Connolly & Doyle 1984); community membership (Sutton-Smith, 1997); and even the origin of culture itself (Huizinga, 1949; Winnicott, 1971).

Wheatley (1992) observes how, through play, children seek out what adults so often strive to avoid: disequilibrium, novelty, loss of control, and surprise. VanderVen offers the metaphor of the "protean self," suggesting that play helps children learn to adapt and respond dynamically to change, by preparing them to live in an unpredictable, chaotic world.

Whereas the literature on self-regulation in play emphasizes cognitive and linguistic, left-brain competencies in the developing child (Berk, Mann, & Ogan, 2006; Vygotsky, 1986), the literature on self-regulation within interpersonal neurobiology (Schore, 1994, 2012; Siegel, 1999) emphasizes the affective and arousal, right-brain foundation necessary for words later to take hold (Panksepp, 2008).

THE IMPORTANCE OF GAMES

Since I highlight in this chapter games that emerged implicitly in service of affect regulation during psychotherapy with the patient "Gus," it is useful to understand the developmental functions of games. From the start of life, parents intuitively stage games at regulatory edges of emotional and social development.

Consider peek-a-boo and hide-and-seek, both of which lurk at the edges of abandonment fears. In these simple games, the danger of the Other potentially lost dissolves into the joy of the Other soon found. A baby's delight in "now you see me, now you don't" sets the rhythm for the capacity to retain internal connection to others despite breaks in physical proximity. Through acts of appearing, disappearing, and reappearing, the baby internalizes a temporal sequence of positive engagement and disengagement. The game of peek-a-boo morphs into a more advanced version of hide-and-seek as toddlers become more mobile and the game spans greater physical distances. Hide-and-seek in particular sets the stage for turn taking and capacities to be "alone in the presence of others," as Winnicott (1971) so beautifully phrased it.

When a father tosses his baby high up into the air and then catches her, this game builds trust amid her fear of falling. The roller-coaster ride from negative to positive emotional states enhances affect regulation and builds resilience as well as tolerance for emotional intensity. All of this is necessary to weather the ups and downs of intimate contact with others. Later, rough and tumble play at the edge of real fighting helps calm aggression. In both cases, the delight derives from riding the edge; were this really terror, and were the child really in danger, the play would stop or turn to torment, when emotional repair would become necessary.

In *Play, Dreams, and Imitation in Childhood*, Piaget (1962) outlined a developmental sequence whereby early imagination gets subjugated to increasing constraints of reality, as rules of play become more explicit and games become more formalized. Singer and Singer (1990, 2005) took issue with Piaget's perspective. They suggest that imagination doesn't disappear when reality rushes in, but instead goes underground, where it remains active in the form of intellectual play and fantasized paths related to future potential.

In previous writings (Marks-Tarlow, 2010, 2012a), I have gone a step beyond Piaget and the Singers by describing the centrality of imagination to healthy self-development. I describe a two-step process by which children use the free play of imagination, first to become oriented and later to navigate through social spaces. During early and middle childhood, games of imagination help young children orient as they calibrate and coordinate internal emotional, cognitive, and imaginal faculties with outer sensory, social, and motor responses.

By initially folding objects and people located in outside reality into internal realms through fantasy play, children can freely explore outer worlds from the safety of internally created space. This prepares them later to navigate intuitively, in light of outside informational and social cues. Once inner and outer faculties are calibrated and fully aligned, children stand a better chance of maintaining the integration and integrity of their core selves, even when subsequently bombarded by outside influences. Unfortunately, as we shall see, this kind of integration and integrity that ultimately leads to a sense of wholeness was precisely what was missing in the case to come.

If all goes well, then children become grounded throughout their lives in the flexible adaptability, creativity, and wisdom of their own intuition. Under the best circumstances, imagination continues to light the path throughout life, and mastery is gained conceiving and then actualizing future paths. Early emotional safety translates into open, engaged stances later on.

However, if emotional safety is absent during early play, something very different is likely to occur later on. Barriers are erected between inner and outer realms. Imagination no longer supplies a beacon to navigate outer worlds and future paths. Instead, imagination becomes a retreat against reality, and fantasy serves as a defense against contact with others. I demonstrate this with the case of Gus, in which we see how implicit games of psychotherapy resonate both with the successes and failures of early play.

GAMES IN PSYCHOTHERAPY

Winnicott (1979) was well aware of the importance of games to psychotherapy. He loved to play the squiggle game, an unstructured method designed to elicit children's thoughts and feelings. Winnicott would fashion a scribble on a sheet of paper. He would then hand it over to his patient, who might transform the sea of scrawls into a great white whale. Conversely, Winnicott might request that his young patient begin with the scribble, which he might then transform into the tangled branches of an oak tree's embrace.

By completing one another's work, Winnicott and the patient quite literally embodied the mutuality of meaning-making within the therapeutic exchange. By transmuting underlying chaos into recognizable forms, the squiggle game illuminates the importance of interpersonal creativity as well as the excitement of spontaneous emergence within the therapeutic relationship. By capitalizing on chance, cooperation, and ambiguity, the game illuminates intersubjective space as a co-constructed, fertile zone of transaction between patient and therapist.

Winnicott's squiggle game is deliberately offered and consciously played. By contrast, most games in psychotherapy emerge implicitly and spontaneously, just beneath the edges of conscious awareness. And one game emerges above all others to be played universally between therapists and patients—the game of hide-and-seek (Marks-Tarlow, 2012a, 2012b). Patients may hide consciously and deliberately, as when addicts lie or psychopaths conceal information. Or patients may hide unconsciously, such as severely depressed people who retreat from the world, contracting their social horizons and constricting with guilt or shame. Most of the time, patients hide metaphorically speaking, by masking their true feelings and desires, but sometimes patients hide quite literally, by missing or forgetting sessions. Patients implicitly hide for many reasons, all emotional, whether out of fear, shame, or guilt, followed by hope, dread, or expectations of therapists seeking and finding them.

As a clinical example of hide-and-seek, I previously wrote about the case of Suzette (Marks-Tarlow, 2012a), who had left her hometown across the country and traveled to Los Angeles in hopes of becoming an actress. When she failed to actualize her dreams, Suzette slipped quite far, falling dangerously close to the netherworld of prostitution.

On the one hand, Suzette was hiding from others by concealing what was going on; on the other hand, she was hiding from herself by convincing herself that giving massages with a "happy twist" at the end wasn't problematic, because she wasn't removing her own clothes. After finding herself arrested during a sting operation, Suzette sought psychotherapy in order to address and break out of her negative life patterns. Upon admitting she'd been "living a lie," Suzette was quickly able to get her life back on track again.

While Suzette's was a case of conscious hiding, more often patients seem to hide out of dissociated emotion. When this occurs, patients hide even more thoroughly from themselves than Suzette did. They then require our assistance to break through their own defensive barriers. The case of Gus falls into this category.

The impulse toward hide-and-seek is not limited to patients; it also comes from therapists, in what is by nature a reciprocal game. Every clinician must negotiate the dilemma of how

much to reveal versus how much to conceal. There is no fixed answer to this question. Ever-shifting boundaries will depend sensitively on the dynamics of the moment. We therapists continually and implicitly ask ourselves: Do I speak of the horror I now feel in response to this patient's lapse of judgment? Do I simply let him read my emotion implicitly, as advertised with my facial expression and body language? Perhaps I go a step further in an attempt to actively conceal my emotions from the patient's detection, knowing how shame-prone that patient is as triggered by even the tiniest signs of disapproval?

I once treated a patient—I'll call him Bill, to protect his identity—who told me he had just faked a suicide attempt, out of anger, in front of a young lady who was recovering from her own suicide attempt. If I could have hidden my disgust and contempt, I would have. For I became convinced that Bill left treatment prematurely precisely because he was able to read my emotions all over my face and body, and this was not helpful to him.

Clearly, the issues here are complex. The reader might ask: Would you have sanctioned his heinous behavior by masking your disapproval? And if you could have, should you have? Was it more important to his therapy that he learn a basic moral lesson? Or was he trying to hide behind his bratty behavior?

By contrast to general agreement that patients should be sought out and fully engaged, different schools of psychotherapy disagree on how much clinicians should hide versus revealing themselves during psychotherapy. Indeed, this may be one of the biggest differences between theoretical schools.

Cognitively oriented therapists tend to view the self of the therapist as invisible and a nonfactor in treatment. Classical Freudian analysts conceal the self in order to grant plenty of room for patient projections. Gestalt therapists, by contrast, go to the opposite extreme of self-revelation, valuing real contact and direct experience over intellectual analysis and indirect interpretation. In my early years of clinical training in Gestalt psychotherapy, I recall some horrific rumors about Fritz Perls, the founder of Gestalt psychotherapy, who reputedly played the dangerous game of calling the bluff of a chronically depressed woman by suggesting she stop talking about suicide and simply "get it over with."

In recent decades, Gestalt therapists are less confrontational and more reluctant to play games of brinkmanship. A stance of greater compassion often blends seamlessly with that of contemporary psychoanalysts. Classical Freudian psychotherapy is considered a one-person therapy, because the only person of significance in the room is the patient. By contrast, contemporary psychoanalysis is highly relational and considered a two-person therapy, because the personhood of the therapist is considered so vital to the intersubjective field.

From a two-person perspective, there is no such thing as therapist neutrality. To hide or to withhold information about one's own point of view within certain therapeutic moments could be considered cruel or sadistic, for example with patients who harbor histories of neglect or abandonment. This is one reason why the New York school of contemporary psychoanalysis elevates authenticity to the forefront of its therapist values.

Self-psychology, a contemporary form of psychoanalysis, derived from the work of Heinz Kohut, holds that the "self state" needs of patients, including their sense of worth and well-being, can only be met through relationship with others. By tracking how the therapist's real self either facilitates or interferes with the emotional needs of patients, self-psychologists allow patients to "use" the therapist's self however it may be needed. A highly narcissistic patient with little tolerance for the full presence of others might elicit very little therapist self-revelation, while a patient with borderline personality disorder who cannot tolerate the absence of the other might elicit a great deal of therapist self-revelation. Self-psychology jokingly has been referred to as a "one and a half" person psychology.

The two-person perspective of relational psychoanalysis dovetails with my own background, which began with Gestalt training, proceeded to self-psychology, and then to interpersonal neurobiology with Allan Schore. It also dovetails with the frontiers of my interests in combining chaos theory, complexity theory, fractal geometry, and other nonlinear sciences, with clinical practice (see Marks-Tarlow, 2008), as inspired largely by my friendship with the Nobel-winning physicist Richard Feynman.

As should be clear from the examples above, the role of self-disclosure during psychotherapy has been controversial. Most schools of psychotherapy agree on the "seek" part of hide-and-seek. Virtually all therapists seek out the inner emotions and truths of their patients, in order to help them feel known, and as a means of helping them to know themselves more fully. And yet, even this principle is not universal.

I recently learned of a marriage counselor who bases her technique on a twelve-step model by telling couples, "I'm not interested in hearing your story. Every person either wants respect or adoration. You tell me which you want; I'll tell you what to do." But this is the exception; most of us do take great interest in what our patients have to say. Some of us are more active in the seeking pursuit.

I, for one, often ask questions while making probing observations. I individualize my treatment to whoever walks through my door. All of my training and experience lead me to believe that clinical intuition is the highest and most complex skill of all (see Marks-Tarlow, 2012a). Given that clinical intuition is one variation on everyday intuition that derives from the freedom for imaginative play, perhaps it is not surprising that intuition is at the basis of the play and games that arise so naturally during the course of psychotherapy.

THE CASE OF GUS

In order to see how play and games operate during psychotherapy at the interface between implicit and explicit levels, I now introduce the case of Gus, about which I have written previously (Marks-Tarlow, 2011, 2012a). When Gus first contacted me for therapy, he was a sixty-two-year-old man in his second marriage. On the phone Gus was blunt about what he wanted. During lovemaking with his wife, he experienced himself as a woman. Out of fear of losing her, he desired to rid himself of this experience.

While immediately and instinctively I recoiled inside at Gus's intention to be rid of any aspect of self, out loud I expressed doubt that this was possible or even desirable. I offered an alternative path—to help Gus understand and make meaning out of his experience. Despite declaring his lack of interest in insight, Gus made an appointment to come in.

During our first session, Gus announced he had tried eight sessions of therapy once before, which he discontinued after being diagnosed with gender identity disorder. This diagnosis did not feel right to him. It seemed too simplistic, especially as Gus was not interested in changing his gender, body, or marriage. Gus had done extensive research on the Internet. None of the diagnostic categories he encountered seemed to fit. Immediately, he wanted my thoughts on the matter of diagnosis.

I sensed great complexity in Gus as a person and great emotional danger in fulfilling either of his initial requests. Despite his stated desire to be neatly categorized so that his "symptom" could be cleanly excised, Gus's urgency to be diagnosed felt "off" to me. After all, hadn't he just left a round of psychotherapy after being diagnosed? Intuitively, Gus's experience seemed far too complex to fit into a neat little diagnostic box.

Over time, we both came to understand his very desire to be diagnosed as symptomatic of unhealthy inner conflict. Gus's conscious yearning for a label to help rid him of his experience

of himself as a woman reflected an inner violence he was inviting me to participate in yet paradoxically needed me to resist, if I were truly to prove to be a safe container for his wholeness.

Amid such a wide gap between explicit (conscious, verbal) and implicit (nonconscious, nonverbal) levels of our communication, perhaps it is little wonder that the diagnostic picture itself began to morph along with the contours of the therapeutic relationship. Initially we talked about Gus's experience of himself as a woman as something he *did*, a *behavior* he voluntarily initiated, both during sex with his wife and during masturbation alone. Then it appeared to be a *fetish* as the frequency increased. Then a *fantasy* as the experience became more positive and geared toward stress reduction.

But as his experience of himself as a woman became more and more linked to evading and avoiding negative emotion, we eventually came to understand Gus's states of mind∕body∕brain to involve not something he did so much as Gus's *dissociation* from integral aspects of his *being*, arising from early relational trauma. Eventually, we landed on the diagnostic picture of dissociative identity disorder (formerly multiple personality disorder), after Gus's female form (Simone) became so completely autonomous as to take on a life of its own. Instead of being bidden during times of stress, Simone spontaneously began to take over Gus's body and consciousness. The first time this happened in public, Gus became frozen in fear and self-consciousness.

With these morphing symptoms—from Gus controlling the switches to Simone "taking over"—I came to recognize the sharp contrast between Gus's conscious desire to be seen and categorized versus his body's unconscious flight from view as well as from simple labels. Different aspects of Gus were coming forth to seek, while others were drawing back to hide, all at the same time.

With hide-and-seek the prototypical game of psychotherapy, from our very first contact on the phone Gus and I were "playing" our own unique version, which amounted to a test of trust, including some very complicated rules of engagement and disengagement. Initially, I had to pass the test by disregarding what Gus consciously sought and asked of me, in favor of supporting what he unconsciously needed, but was too terrified of being hurt, at the risk of emotional annihilation, to realize. Over and over we played new iterations of the same "game." Each time I passed the test—by remaining emotionally engaged and accepting of all of Gus without judgment or exploitation—his trust increased. And with additional trust came greater safety for Gus to show more of himself to me externally, while internally he connected with more and more dissociated bits of self.

Here is the developmental picture as I came to understand it. From the start, dating all the way back to his early days in the womb, Gus had been emotionally traumatized. Gus's mother became pregnant by accident and deeply resented giving up her own rising stardom as a jazz singer in order to care for a baby. Her suffering during pregnancy worsened with the dissolution of all relations with Gus's biological father. Left alone and with the burden of an unwanted child, Gus's mother became physically abusive during his childhood and emotionally devastating throughout his life. The very core of this sensitive boy felt wiped out by his mother's self-absorbed, narcissistic ways; fortunately, things improved several years later, when a loving stepfather came on the scene and eventually adopted Gus.

In response to the highly disorganizing effect of his early childhood, Gus learned to play a game of hide-and-seek with himself. He learned to split off, or dissociate, unwanted emotional parts of himself, for which he subsequently spent years searching. Before therapy, Gus feared that he must give up the fantasy of himself as a woman in order to become potent as a man.

Over time, and through reassurances by me of his safety to be all of himself, we came to understand the opposite. Gus's very attempt to give up pieces of himself in hopes of preserving relationships with others was itself what led to feelings of impotency, implosion, and burnout. Only by reclaiming these split-off pieces would Gus come to feel powerful and more whole.

Gus's transformation into Simone was not just about inner sensibilities, but also included his felt experience as connected to outer form. In addition to processing the changes in body sense, we also came to understand Gus's transformations into Simone partly in symbolic terms. The constellation reflected opposite, indeed contradictory, impulses to dissociate unbearable feelings while yearning for connection to his feeling side, along with the rich internal life it afforded him.

From a neurobiological perspective, Gus's symptom appeared to be a left-brain logical mind that had become dissociated from a right-brain, relational side. Although Gus's two personalities inadvertently fit the stereotype of the rational man and the emotion-filled woman, my patient did not endorse such stereotypes in how he lived his life, in that Gus loved to cook and was incredibly warm, loving, and empathetic to his own adopted son.

Over our years of psychotherapy together, Gus made peace with his female side. He came to appreciate what Simone had to offer. This included reconnecting with the emotionally evocative music Gus used to compose, but had given up after the death of his adoptive father. Here is how Gus described his connection to music in his own terms:

> All of my music has me in it. Some of my music, consisting of my "special" songs, is effectively my journal, with my deepest thoughts and emotions clearly visible. These songs have especially powerful emotional content for me, with which I am not comfortable feeling or exposing. Not surprisingly, I share those songs with maybe only four people, the people with whom I feel particularly safe."
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> My "other" songs also always have "me" in them, but in a non-apparent way. It may just be a single line of lyric, but in order to see me, you have to take that line and put it into the proper context from where it really comes. Even then, if you asked me about it, I'd just deny it and point you back to the context of the lyric. It's kind of perfect in that way: I can say it, put it in plain view, yet no one will ever see me.

Eventually, in light of the lovely songs that emerged, Gus came to love his female side and the role she played as muse. One day, given his greater internal comfort, Gus speculated that perhaps he was ready to terminate our psychotherapy. Yet he still felt confused about what full integration of his male and female sides really meant and even asked, "Do I *have* to integrate?" To Gus, integration meant combining his two sides, and he could not see how this could possibly work, given two different emotional compositions and even bodies. In light of what happened next, this proved the start of yet another round of hide-and-seek.

The following week, Gus entered my office with a huge cut on his forehead, explaining he had had a terrible car accident. He had been driving his wife and son to celebrate a family occasion when he unwittingly made a left turn with an obscured sightline. Gus's vehicle was hit on the passenger side by an oncoming vehicle. His van rolled sideways and landed upside down. As gas poured out of the car, the family negotiated an emergency evacuation through the roof. Miraculously, the accident occurred outside the tower of a medical center, and fortunately, no one in either car was seriously hurt.

In relating the tale of the accident, Gus kept focusing on tiny details of what happened. Later, he admitted to doing this in order to make it through the account without breaking down emotionally. Gus explained that he was doing his best to split off and contain his emotion. During that session, he also emphasized over and over how lucky he and his family had been.

Had the car been struck another inch in one direction or another, his wife surely would have been killed.

As I listened, I could feel my own insides somersaulting. The accident sounded unbelievably traumatic. Meanwhile, I watched Gus's face with close attention. All the tiny muscles surrounding his eyes seemed to play their own version of hide-and-seek, as they edged toward the horror, only to dart away again. At the end of the clinical hour, I made an unusual declaration to Gus: that I suspected he needed to cry.

Next session, Gus acknowledged I had been right about the crying. After reading details of the police report and seeing the photograph of the smashed car, he wound up convulsing into tears in the arms of his wife. This was the first time he had had such an experience with anyone. Later in the session, I asked Gus a rather unusual question, who cried—Gus's male or female side? Gus responded that he had been too "deeply immersed into the experience" to know. There had been no internal gatekeeper, no defenses erected, and no witness who stood outside of himself to watch and judge. Only tears. A couple of minutes later, Gus queried why I had asked. "Because that was integration," I responded.

The following week, Gus told me about a dream he'd had:

> It is Thursday morning. I walk into your office for a session. There are all kinds of toys on the floor. I look puzzled; you reply, "I have a child client. Would you like to play with the toys?" "Not particularly," I respond. "**Why** don't you want to play with the toys?" As I pause to think about answering your question, I realize I feel trapped; there is no way out. "Okay, I will play with the toys." I sit on the floor and start to play like a little kid, like a 4-year old. I make the "vvvrrrrooommm" sounds of the cars. Then I set up the collision, using the tower for the medical building. When I finish, I immediately have a tantrum, screaming and throwing the blocks all around your office. Then the anger dissolves into tears. I cry and cry, which is what I needed to do.

Gus and I talked about the meaning of the dream, playing with multiple interpretations for a couple of sessions. The following week Gus made an announcement. The more he thought about it, the more he became convinced that the dream was actually *not* about the car accident. Instead, Gus believed the dream revealed the territory of what takes place between us, as patient and therapist during psychotherapy.

Here is how Gus explained it. Up until this point, he and I had been playing a game of chess. He cited the example of the beginning of his dream, when I was grilling Gus about why he didn't want to play with the toys. Internally, in his dream, he went through every possible answer. But Gus just knew he was going to "lose." There was no way out. Gus described our game of chess as cerebral and defensive. He would set up strong lines of defense in order to maneuver and "block" me in any way he could. The ultimate goal was to avoid going where I wanted him to go—toward his vulnerable core, and especially, toward strong emotion.

At the end of that very illuminating and productive session Gus emphatically announced, "I don't want to play chess anymore!" Indeed, from that point forward, the feeling in the room changed. It is much more open, undefended, and spontaneous. Gus is less likely to come in with carefully fixed agendas. Often, he reveals his own "hand" before trying to solicit responses from me. Together, we have grown comfortable and intimate discussing nuances of our relationship. We roll the diamond of trust over and over together, to cherish and examine each precious facet. Recently, we have even visited the scariest and least known places inside Gus—the ones brimming with terror and rage.

Readers may wonder why people who seek out psychotherapy would play hide-and-seek, when they are there of their own accord in the first place. This rational perspective aligns with the surface truth, yet the underlying picture is more complicated. People play games with themselves, such as not admitting the truth of an addiction or pretending tender or vulnerable

feelings don't exist. They then become too internally unsafe with their own experiences to share them with others. This was certainly the case for Gus. The antidote to this state of affairs during psychotherapy is to provide enough external, relational safety to reverse inner defenses.

I must admit that the underground streams of transaction within the relational unconscious never cease to amaze me! I don't see children in my practice nor conduct formal play therapy. Gus had no awareness of my writings on the subject of play. His dream about play therapy came just as I was considering what to write for this chapter in the *Handbook of the Study of Play*. In this way, the underground strands of our two lives entwined perfectly. On Gus's end, the timing was right to expose and shift the implicit rules of our play. This proved a beautiful and quite paradoxical way to take control over his therapy at the very same time that Gus felt safe enough to relinquish control. And of course, taking control and relinquishing control is often the essence of games—and most always a part of play.

What I had seen as a game of hide-and-seek had appeared to Gus as a game of chess. All his pieces were lined up to defend against his own emotional exposure and expression. Yet with Gus's dream, and his subsequent declaration that he no longer wished to play chess, the rules and rhythms of our emotional engagement changed. We moved from being adversaries on different teams to cooperatively playing on the same team. We moved from a zero-sum game scenario, where one person wins at the other's expense, to a win-win scenario, where everybody gains from therapeutic progress.

As Gus felt safe enough to shed his defenses and reveal his hand, the game of hide-and-seek returned to its roots in peek-a-boo, where the joy is in the playing and not in the winning, and everybody takes delight in seeking as well as in being found. At this stage of treatment, the quality of intersubjective space became richer and more complex, as we both grew safer to "put our cards on the table."

PLAY AND PARADOX IN PSYCHOTHERAPY

With paradox so frequently embedded in the core of complex systems (Marks-Tarlow, 2004, 2008b; Marks-Tarlow, Robertson & Combs, 2002), it is not surprising that numerous researchers (Monighan-Nourot, 1998; Schwartzman, 1978; Sutton-Smith, 1997) point toward opposites within play. VanderVen (2004) cautions against adopting an overly simplistic, either-or stance as she lays out play's common dichotomies: fantasy-reality, work-play, process-product, pleasurable-serious, rule based–free flowing, choice-requirement, freedom-constraint, and past-future.

Fromberg (2002) highlights opportunities for insight and learning afforded to children through the dialectic tension of bipolar pairs. The deep implicit structure of play underlying psychotherapy with Gus likewise points to the tension of opposites. Although we were playing, something very serious was going on, as meanwhile, psychotherapy danced between opposite poles of engaged/disengaged, trust/ mistrust, revealing/concealing, male/female, love/hate, conscious/unconscious, explicit/implicit, war/peace, piece/whole.

Rather than trying to resolve the tension of opposites, a nonlinear perspective elevates paradox to a pivotal role during the emergence of novelty and creativity (Marks-Tarlow, 2004, 2008b). We understand this readily when reflecting on qualities of young children's pretend play. Twists and turns in play narratives not infrequently trigger a 180-degree turn into self-contradiction. One minute a child, as fireman, urgently rushes to the scene of a blazing fire, intent on saving a house from the flames. The next minute, our little hero morphs into a villain determined to toss the house into the fire instead. The coexistence of such opposites fires up children's passions within a safe environment, where nothing really burns and everything

fuels the flames of creative inspiration. And so it was with Gus. As our therapy progressed and deepened, the stakes got higher and our mutual trust grew. Meanwhile, the quality of our play shifted as Gus tasted the fruits of being found and not just the terrors associated with hiding.

In the case of Gus, play was central and deeply embedded in implicit levels of our communication. Yet at just the right moment, the game reached fertile edges of conscious awareness. Freud developed his system of psychoanalysis in order to make the unconscious conscious. At the other end of the spectrum, cognitive-behavioral therapists pay exclusive attention to conscious levels and explicit content. Even though deep change can happen without conscious awareness (for a discussion of this topic, see Marks-Tarlow, 2012a), it behooves us to understand the implicit processes that intuitively guide us.

When it comes to psychotherapy, the importance of nonconscious levels of engagement, including play, cannot be overemphasized. The seduction of our symbolizing side may easily give a false impression that play originates from higher cortical capabilities. Yet this is not the case, as demonstrated dramatically by Panksepp (1998) in a striking experiment. Panksepp's lab compared the play of normal rats to that of rats whose cerebral cortices were surgically removed. Graduate students were asked to observe and record the behaviors of the two groups, as well as to guess which group of rats was normal and which was decorticated. Invariably the students guessed wrong, consistently mistaking the invigorated, boisterous antics of decorticated rats for normal ones, while the subdued behavior of rats whose brains were intact appeared less healthy.

Certainly we humans love to use higher-thinking centers to continually innovate interesting, more sophisticated games. The cutting edge of technology often manifests in this way. The bright side to this is thrilling virtual play, while the shadow side includes nightmare visions like *The Matrix* or *Inception*, where play turns deadly or technology entraps rather than frees and expands our worlds. When we go to the movies we're still flirting with the nightmare, by playing with it. Yet like all other emotional and motivational circuits, the urge to play derives from primitive brain structures originating from the brainstem and subcortical areas.

The human neocortex is necessary for any emotion to reach full awareness, but this uniquely human area cannot generate feeling states, all of which originate in subcortical neural areas, beneath reflective awareness. The cortical level serves only to register, modify, or transform these deep urges, not to create them. The primacy of emotion in the brain and deep, subcortical roots of our primary motivations, including play, are landmark discoveries whose full implications are far from known. During psychotherapy, the natural impulse to play arises unbidden and becomes yet another royal road to explore the relational unconscious.

CONCLUSION

How and why psychotherapists and patients play together sets the emotional tone for sessions and determines the *feel* of intersubjective space. Play is a vital instinct that is hard-wired deeply into the mammalian brain. This chapter looked at the interpersonal neurobiology of attachment to understand how the self grows, unfolds, and builds new structure through play. Freedom to play without inhibition or constriction is a key ingredient for joy, interest, passion, and vitality later in life. Just as children reveal their growing edge during play, so too do therapists. Because play is developmentally crucial to achieving cognitive, emotional, behavioral, and social flexibility and complexity, it remains a central part of the repertoire of clinical intuition.

Sometimes we therapists succumb to the instinct to play in order to lighten up the atmosphere. At other times the intuitive urge to play models an open, nondefensive attitude toward

ourselves and others. Whether initiated by the therapist or patient, the instinct to play tests safety and encourages interpersonal experimentation. The invitation to play is often a bid for connection that allows coordination, mutuality, and turn-taking. The more that safety is experienced, the more novelty and growth become possible.

Through the play of psychotherapy, clinicians use intuition to feel their way into the unique contours of each person. This is a bold suggestion: to conceive of psychotherapy as more fluid then any reified theory or manualized treatment approach implies. Yet in light of the interpersonal neurobiology of play, I believe this is necessary to reach deep levels of embodied change during psychotherapy. Through the play of language, clinicians find special terms reserved for each patient alone. Through the play of different expressions, special greetings, and unique rituals, psychotherapists and patients co-create meaning.

At implicit levels, psychotherapists play with their focus to gently guide patients toward new directions. At explicit levels, psychotherapists play with framing and assigning meaning in service of new hope, healing, growth, and purpose. It behooves all psychotherapists to remain conscious of the deep, implicit structure of play during psychotherapy. The more conscious we can be of the process, the less we will need to act out games far beneath the thresholds of awareness. Certainly this was the case for Gus. Rather than hiding from our neurobiological imperatives, we can joyfully expose the gig in service of co-creating new rules of engagement with self and others.

REFERENCES

Baer, J. (1993). *Creativity and divergent thinking: A task specific approach*. New York: Laurence Erlbaum.

Bateson, G. (1976). A theory of play and fantasy. In J. S. Bruner, A. Jolly, & K. Sylva (Eds.), *Play—Its role in development and evolution* (pp.). New York: Basic Books.

Beebe, B., & Sloate, F. (1982). Assessment and treatment of difficulties in mother-infant attunement in the first three years of life: A case history. *Psychoanalytic Inquiries*, *1*, 601–623.

Bekoff, M. (2004). Wild justice and fair play: Cooperation, forgiveness, and morality in animals. *Biology and Philosophy*, *19*(4), 489–520.

Bekoff, M., & Pierce, J. (2009). *Wild justice, the moral life of animals*. Chicago: University of Chicago Press.

Berk, L., Mann, T., & Ogan, A. (2006). Make-believe play: Wellspring for development of self-regulation. In D. Singer, R Golinkoff, & K. Hirsh-Pasek (Eds.), *Play = Learning* (pp. 74–100). New York: Oxford University Press.

Bowlby, J. (1969). *Attachment*. (Vol. 1). New York: Basic Books.

———. (1973). *Separation: Anxiety & anger*, volume 2, Attachment and loss. (International Psycho-Analytical Library, No. 95). London: Hogarth Press.

Bruner, J. (1990). *Acts of meaning*. Cambridge, MA: Harvard University Press.

Connolly, J., & Doyle, A. (1984). Relation of social fantasy play to social competence in preschoolers. *Developmental Psychology, 20*, 5, 797–806.

Darwin, C. (1872). *The expression of the emotions in man and animals*. London: John Murray.

Davies, B. (1997). The construction of gendered identity through play. In B. Davies & D. Corson (Eds.), *Encyclopedia of language and education: Oral discourse and education* (Vol.3, pp. 116–124). Dordrecht: Kluwer.

Denzin, N. (2005). Play, games and interaction: The contexts of childhood socialization. *Sociological Quarterly, 16*, 4, 458–478.

Ekman, P. (Ed.). (2003). *Emotions inside out: 130 years after Darwin's "The expression of the emotions in man and animals"*. (1st ed.). New York: New York Academy of Sciences.

Fisher, H. (1994). *Anatomy of love: A natural history of mating, marriage, and why we stray*. New York: Ballantine Books.

Fosha, D., Siegel, D., & Solomon, M. (2009). *The healing power of emotion: Affective neuroscience, development & clinical practice*. New York: Norton.

Frederickson, B. (1998). What good are positive emotions? *Review of General Psychology, 2*(3), 300–319.

———. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist, 56*(3), 218–256.

Fromberg, D. (2002). Play *and meaning in early childhood education*. Boston: Allyn and Bacon.

Garvey, C. (1977). *Play*. Cambridge, MA: Harvard University Press.

Greenberg, D., Cicchetti, & Cummings, E. (1990) (Eds.), *Attachment in the preschool years: Theory, research and intervention*. Chicago: University of Chicago Press.

Huizinga, J. (1949). *Homo ludens: a study of the play-element in culture* (F. F. C. Hull, Trans). London: Routledge & Kegan Paul.

Kindler, A. (2010). Spontaneity and improvisation in psychoanalysis. *Psychoanalytic Inquiry, 30*, 222–234.

Knafo, D. (2012). *Dancing with the unconscious: The art of psychoanalysis and the psychoanalysis of art*. New York: Routledge.

Knoblauch, S. (2000). *The musical edge of therapeutic dialogue*. Hillsdale, NJ: The Analytic Press.

Kurtz, S. (1977). *The art of unknowing: Dimensions of openness in analytic therapy*. Lanham, MD: Jason Aronson.

Marks-Tarlow, T. (2004). Semiotic seams: Fractal dynamics of reentry. *Cybernetics & Human Knowing, 11*, 1, 49–62.

———. (2008). *Psyche's veil: Psychotherapy, fractals and complexity*. London: Routledge.

———. (2010). The fractal self at play. *American Journal of Play, 3*(1), 31–62.

———. (2011). Merging and emerging: A nonlinear portrait of intersubjectivity during psychotherapy. *Psychoanalytic Dialogues, 21*, 110–127.

———. (2012a). *Clinical intuition in psychotherapy: The neurobiology of embodied response*. New York: Norton.

———. (2012b). The play of psychotherapy. *American Journal of Play, 4*, 3, 352–377.

Marks-Tarlow, T., Robertson, R., & Combs, A. (2002). The psychological significance of reentry. In R. Trappl (Ed.), *Cybernetics and Systems, 2000* (Vol.2, pp. 221–225). Vienna: .

Monighan-Nourot, P. (1998). Sociodramatic play: Pretending together. In D. Bergen & D. Fromberg (Eds.), *Play from birth to twelve and beyond: Contexts, perspectives and meanings* (pp. 378–391). New York: Garland.

Nagel, J. (2012). *Melodies of the mind: Connections between psychoanalysis and music*. New York: Routledge.

Nicolopoulou, A. (2005). Play and narrative in the process of development: Commonalities, differences, and interrelations, *Cognitive Development, 20*, 495–502.

Panksepp, J. (1998). *Affective neuroscience: The foundations of human and animal emotions*. New York: Oxford University Press.

———. (2010). Science of the brain as a gateway to understanding play. *American Journal of Play, 2*(3), 245–277.

Parsons, M. (1999). The logic of play in psychoanalysis. *International Journal of Psychoanalysis, 5*, 871–874.

Piaget, J. (1962). *Play, dreams, and imitation in childhood* (C. Gattegno & F Hodgson, Trans.). New York: Norton.

Prior, V., & Glaser, D. (2006). *Understanding attachment and attachment disorders: Theory, evidence and practice*. (Child and Adolescent Mental Health, RCPRTU). London: Jessica Kingsley.

Schore, A. (1994). *Affect regulation and the origins of the self*. New York: Erlbaum.

———. (1997). Early organization of the nonlinear right brain and development of a predisposition to psychiatric disorders, *Development and Psychopathology, 9*, 595–631.

———. (2012). *The art of the science of psychotherapy*. New York: Norton.

Schwartzman, R. (1978). *Transformations: The anthropology of children's play*. New York: Plenum Press.

Siegel, D. (1999). *The developing mind: How relationship and the brain interact to shape who we are*. New York: Guilford.

Singer, D., & Singer, J. (1990). *The house of make-believe: Children's play and the developing imagination*. Cambridge, MA: Harvard University Press.

———. (2005). *Imagination and play in the electronic age*. Cambridge, MA: Harvard University Press.

Smilansky, S. (1990). Sociodramatic play: Its relevance to behavior and achievement in school. In E. Klugman & S. Smilansky (Eds.), *Children's play and learning* (pp.). New York: Teacher's College.

Snow, C., & Ferguson, C. (Eds.). (1977). *Talking to children: Language input and acquisition*. Cambridge, UK: Cambridge University Press.

Stern, D. (1985). *The interpersonal world of the infant*. New York: Basic Books.

Sutton-Smith, B. (Ed.). (1979). *Play and learning*. New York: Gardner Press.

———. (1997). *The ambiguity of play*. Cambridge, MA: Harvard University Press.

VanderVen, K. (1998). Play, Proteus and paradox: Education for a chaotic and supersymmetric world. In D. Fromberg & D. Bergen (Eds.), *Play from birth to twelve and beyond: Contexts, perspectives, and meanings* (pp. 119–132). New York: Garland.

———. (2004). Beyond fun and games towards a meaningful theory of play: Can a hermeneutic perspective contribute? In S. Reifel & M. Brown (Eds.), *Social contexts of early education, and reconceptualizing play* (Vol. II, pp. 165–205). New York: Elsevier.

Vygotsky, L. (1978). *Mind in society: The development of higher mental processes*. (M. Cole, V. John-Steiner, S. Scribner, & E. Souberman, Eds. and Trans.). Cambridge, MA: Harvard University Press. (Original work published 1930–1935).

———. (1986). *Thought and language*. (A. Kozulin, Trans.). Cambridge, MA: MIT Press.

Wheatley, M. (1992). *Leadership and the new sciences*. San Francisco: Berrett-Koehler Publishers.

Winnicott, D. W. (1971). *Playing and reality*. New York: Tavistock/Routledge.