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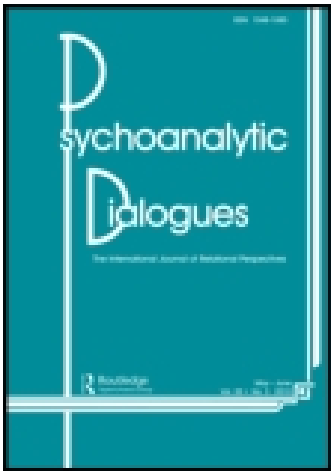

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From Emergency to Emergence: The Deep Structure of Play in Psychotherapy

Terry Marks-Tarlow Ph.D.[a]

[a] Santa Monica, CA

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From Emergency to Emergence: The Deep Structure of Play in Psychotherapy

Terry Marks-Tarlow, Ph.D.
Santa Monica, CA

Games emerge within the deep structure of psychotherapy at implicit rather than explicit levels as relational bids that establish rules of engagement and disengagement. A clinical case demonstrates how the implicit play of psychotherapy stretches regulatory boundaries and allows for the emergence of new structure and higher complexity in a dissociated patient.

This paper addresses the affiliation of play to the therapeutic exchange. I do not refer to play therapy, sandplay, or other *explicit methods* of emotional healing, but focus instead on how play operates *at implicit levels, under the content* of the therapeutic dialogue to indicate shifting relational contours. Through play, mutuality arises as rules of emotional engagement are negotiated—Who will speak? Is it safe? Should I seek intimacy? How will turn-taking take place? Such relational negotiations mimic the structure of early play via body to body exchanges that take place between therapists and patients at edges of conscious awareness.

Using the developmental perspective of interpersonal neurobiology, the multidisciplinary study of how one brain, mind, and body develops in the context of another brain, mind, and body (e.g., Badenoch, 2008; Cozolino, 2005; Marks-Tarlow, 2012a, 2014; Schore, 1997, 2012; Siegel, 1999), I illustrate how the play between therapist and patient derives from mammalian motivational/emotional circuits resembling those between caregiver and infant within early life. I highlight the importance of play for increasing affect tolerance, offering behavioral flexibility, expanding positive emotion, creating intrinsic motivation, and broadening social skills and competencies. I show how emergent games help to structure social space, by dictating patterns of turn-taking and rules of interpersonal coordination.

I offer the case of Gus to illustrate the game of hide-and-seek as the prototypical game of psychotherapy. In its simplistic form, I seek Gus's emotional core, while he hides in fear of becoming emotionally devastated, betrayed, and abandoned, as occurred from infancy onward. There is also an intrapsychic version of the game. With dissociation as his major form of internal defense, Gus hides not just from me but also from unwanted aspects of himself. I end by calling for psychotherapists to pay close attention to implicit games as they arise during psychotherapy.

Correspondence should be addressed to Terry Marks-Tarlow, Ph.D., 1460 7th Street, Suite 304, Santa Monica, CA 90401. E-mail: markstarlow@hotmail.com

Progress and healing can be enhanced when we seek to understand not just our patients, but also the rules of the games that regulate our interactions implicitly.

PLAY MODELS OF PSYCHOTHERAPY

The play of psychotherapy has attracted long-standing interest from clinical theorists such as Meares (2005), Parsons (1999), Pizer (1998), Sanville (2000), and Winnicott (1971). Donald Winnicott, the twentieth-century British pediatrician and psychoanalyst, illustrated how play arises within intersubjective space, which consists of the transitional, paradoxical zone *between* therapist and patient (Winnicott, 1971).

> Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible, then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play. (Winnicott, 1971, p. 44)

To Winnicott, the transitional space that exists between mother and child is the creative source of all symbol, self, and society. In parallel fashion, the transitional space that exists between therapist and patient is the fertile zone for growth and change. Whether during development or psychotherapy, through this zone of relational negotiation, play takes on unique qualities specific to the participants and their alchemical mixture. I enlarge upon Winnicott's ideas by detailing how play arises implicitly as a relational bid to gauge, test, and regulate safety and trust between patient and therapist.

THE IMPORTANCE OF PLAY IN MAMMALS

Play may be ubiquitous across psychotherapy treatment modalities because it is deeply stamped into the brains, bodies, and minds of all mammals in service of open neural wiring. Panksepp (1998, Panksepp & Biven, 2012) has identified seven discrete emotional circuits common to mammals: SEEKING, CARE, LUST, PLAY, PANIC, RAGE, and FEAR, each with 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 brain stem and extends through midlevel limbic mammalian areas, to wind up in the higher 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. Play has developed hand in hand with the attachment system, serving as a major form of bonding between parents and their offspring. A safe and secure baby is free to openly explore the environment and to play in his or her mother's presence (Beebe & Lachmann, 2013; Schore, 1994). Instead of merely responding to the press of innate survival needs, as reptiles do, through play, mammals became proactive, adventurous, and inquisitive.

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HUMAN PLAY

Play in humans resembles play in other mammals by having a critical window for normal development. As with many other mammalian species, children engage in rough-and-tumble play during the early childhood years, which ironically relates to cognitive capacities to settle down and focus attention (Panksepp, 2007). 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 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 (Fonagy & Target, 1996a, 1996b).

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). By utilizing the whole body's gross and fine motor system, play enables the complex coordination of interpersonal rhythms based on safety, trust, escalating arousal, and full engagement in positive emotional states. 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.

Neurobiological, psychological, sociological, and anthropological researchers have identified a host of affective, cognitive, social, and motor capacities that accompany children's play. 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, 1990), 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).

THE PLAY OF IMAGINATION

Whereas most mammals play within a critical window of development, humans often continue playing right into adulthood. Along with its extension throughout the life span, human play differs from that of other species in another significant aspect. Beyond the rough-and-tumble variety common to other mammals, human play also diverges into symbolic realms and imaginative landscapes. Imaginative play is just as important developmentally as rough-and-tumble play for children (Fonagy & Target, 1996a, 1996b), so much so that its absence during peak years, roughly between 3 and 6, is often diagnostic of a variety of problems (Brown, 2009), from specific developmental delays to severe autism.

While play is easily considered frivolous in contemporary culture increasingly oriented toward early academic achievement, therapists and parents should take heed; for play truly is the work

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of childhood. This point is brought home by the early research of Stuart Brown, a psychiatrist at Stanford University. In 1969 Brown worked within prison settings by conducting clinical interviews on 26 young incarcerated murderers. Despite divergent social classes, ethnicities, levels of trauma and deprivation, and varying life opportunities within the prisoners, the only common factor identified among these highly violent, antisocial men was the absence of normal play during childhood.

Children's early creative play is important partly because it coincides with the development of symbolism through language. According to Piaget, fantasy gets increasingly subjugated to constraints of reality as children shift from early sensory-motor play, through mastery play, to symbolic play, and finally to games with rules. As play becomes increasingly symbolic, social, and imaginative, it moves from implicit, preconscious, and nonverbal roots to include more explicit, conscious, and verbal elements. While still facilitated by safe attachment and primary-caretaker involvement, children's play develops in opposite directions simultaneously—toward greater autonomy as well as toward fuller coordination with others.

The seduction of our symbolizing side easily gives the false impression that play emerges from higher cortical capabilities. Yet this is not the case, as dramatically demonstrated by Panksepp (1998). Panksepp's lab compared the play of normal rats to that of rats with their cerebral cortices 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 decorticated. Invariably the students guessed wrong. They consistently mistook the invigorated, boisterous antics of decorticated rats for normal ones, while the subdued behavior of rats whose brains were intact appeared less healthy. That play arises from subcortical areas without any need for cortical involvement underscores how play can arise implicitly during psychotherapy, often without ever reaching conscious awareness.

GAMES EMERGE AT REGULATORY EDGES

Wheatley (1992) observed how, through play, children seek out what adults so often strive to avoid—disequilibrium, novelty, loss of control, and surprise. VanderVen (1998) picked up on Lifton's (1995) metaphor of the "protean self" by suggesting that play helps children learn to adapt and respond dynamically to change, 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 et al., 2006; Vygotsky, 1986), the literature on self-regulation within interpersonal neurobiology (Schore, 1994; Siegel, 1999) emphasizes the affective and arousal, right-brain foundation necessary for words later to take hold (Panksepp, 2008).

Whereas play is less structured and more symbolic in nature, games tend to be rule-governed and designed to sport winners and losers. From an affective perspective, early games between a caregiver and baby are unwittingly staged at the edges of regulatory boundaries (Marks-Tarlow, 2010, 2012a, 2012b). When a father tosses his baby high up into the air and then catches her, this game builds trust amid her terror 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. These close calls help 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 edges. Were this really terror, and were the child really in danger, the play would stop or turn to torment, and emotional repair would become necessary.

Peek-a-boo and hide-and-seek both lurk at regulatory edges of abandonment fears. 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, or object constancy, with 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 especially sets the stage for turn taking and capacities to be "alone in the presence of others" (1971, p. 47), as Winnicott so beautifully phrased it.

GAMES IN PSYCHOTHERAPY

Winnicott (1971) 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 sea of scribbles on a sheet of paper and then hand it over to his patient. By transmuting underlying chaos into recognizable forms, the squiggle game illuminates the importance of turn-taking to 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 was deliberately offered and consciously played. We clinicians sometimes consciously sense the urge to play coming to the fore, as in the deliberate search for new possibilities. I once worked with a psychology student whose critical but demanding mother combined with high degree of perfectionism left her feeling chronically unworthy. Despite the young woman's exceptional brilliance and capability, she had previously flunked her psychology licensing exam multiple times. The research of Carol Dweck (e.g., Mueller & Dweck, 1998) illuminates the "praise paradox"—excessive focus on children's high intelligence tends to boost self-confidence in the short term but produces high degrees of uncertainty related to self-esteem and their true capabilities in the long run. As an antidote to my patient's sense of seriousness and rather obsessive self-preoccupation, we devised a strategy for her next licensing exam—a playful act of defiance. She would begin the exam by scribbling extensively on her scrap paper. This simple, symbolic act of defilement, reminding me as I write these words, of animals pissing on territory in order to mark dominance, was highly effective and worked to break the pattern of this young woman's failure.

Despite such examples, most of the time during psychotherapy, play emerges implicitly, that is, automatically, in bottom-up fashion, from subcortical roots, as a spontaneous and intuitive expression, without conscious evocation or deliberation. If there is one game that emerges implicitly and spontaneously above all others, as universally played between therapists and patients, it is the game of hide-and-seek (Marks-Tarlow, 2012a, 2012b, 2015). Patients may hide consciously and deliberately, as when addicts lie or psychopaths conceal information. Patients may also hide unconsciously, such as when severely depressed people retreat from the world, contract their social horizons, and constrict with guilt or shame. However, in cases of severe addiction or

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depression, hiding represents no game at all, if there is no intention or desire to be found. Or, hiding may be akin to Mitchell's (1986) notion of a gambit, if it is one-sidedly enacted as a narcissistic bid for rescue, with little "area of overlap" between the goals of the therapist and those of the patient, in the true Winnicottian sense of play. While patients usually hide metaphorically, by masking their true feelings and desires, they also at times hide quite literally, by missing or forgetting sessions.

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. The role of self-disclosure during psychotherapy is controversial, with most schools of psychotherapy agreeing more about the "seek" part of the implicit game. 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 assisting them to know themselves more fully. By contrast, how much and when to self-disclose tend to be more controversial and the subject of great debate. The issue gets even more complex when we bring in the implicit level of affect, where we and our patients unconsciously transmit, receive, and process affective signals from one another on an ongoing basis.

In the case that follows, I hope to demonstrate these underground flows as well as how, during psychotherapy, play arises moment to moment as a primary means of navigating through social space. Here, within multiply embedded layers of the therapeutic dialogue, ever-changing rhythms of engagement follow invisible, open conduits of unconscious emotional exchange.

THE CASE OF GUS

I previously wrote about the case of Gus in the pages of this journal to clinically illustrate a complexity model of mental health (Marks-Tarlow, 2011). Psychotherapy with Gus was especially well suited for this purpose, given the incredibly wide gap between explicit versus implicit levels of discourse. Gus was a 62-year-old man in his second marriage who contacted me out of a fierce desire to rid himself of his inner, intermittent experience of being a woman, which he feared might interfere with his marriage. Immediately, I sensed great inner complexity in Gus. I also had a palpable sense of danger in fulfilling Gus's stated agenda, along with his wish to be diagnosed on the spot. I offered Gus an alternative path of understanding and making meaning out of his self-experience, while working together toward a diagnosis.

As the weeks and months passed, Gus and I came to understand and explore how his explicit agenda itself was symptomatic of unhealthy inner conflict. Gus's conscious yearning to be rid of feeling like a woman inside, plus his search for a label to assist in excising this aspect of self, reflected an inner violence he was inviting me to participate in. Yet, he paradoxically needed me to resist this very same violence, if I were truly to serve as a safe container for Gus's wholeness. Meanwhile, amid this yawning maw between explicit (conscious, verbal) and implicit (nonconscious, nonverbal) levels of communication, the diagnostic picture itself began to morph along with the contours of the therapeutic relationship.

Initially we talked about Gus's sense 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

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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.

Gus had left a previous therapy after being diagnosed as transgender. This diagnosis didn't feel right on the basis of extensive research Gus conducted. His experience was not consistently feeling like a woman in a man's body, but sporadically feeling like a woman in a woman's body. Eventually, we landed on the diagnostic picture of Dissociative Identity Disorder at the point that Gus's female form (Michelle) became so completely autonomous as to take on a life of its own. Instead of exclusively bidden during times of stress, Michelle spontaneously, sporadically, and somewhat unpredictably took over Gus's body and inner consciousness.

My previous article (2011), consistent with the perspectives of Galatzer-Levy (2009), Ghent (1992) and Pizer (1998), highlighted five clinical principles evident in this case, derived from nonlinear dynamics:

a. A nonlinear relationship exists between diagnosis and treatment, when symptoms shift with treatment and diagnosis emerges out of it;
b. the intersubjective field is a complex web of feedback loops continually operating on multiple time scales and descriptive levels;
c. the coupled therapist/patient system self-organizes implicitly toward the edge of chaos;
d. at the fertile edge of chaos, novelty and greater system complexity emerge spontaneously; and
e. core therapist/patient dynamics are expressed as recursive, fractal pattern (p. 110).

Rather than repeat case details related to points above, I wish to focus on the formal game structure embedded within the implicit level of treatment. As Gus's symptoms shifted, from being under his control to Michelle "taking over," I began to recognize a 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 both 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 of whether or not it was safe to reveal hidden aspects of self by disregarding what Gus consciously sought and asked of me, in favor of supporting what he unconsciously needed, but was too terrified to receive or even realize, for fear of being hurt, and even worse, at the risk of emotional annihilation. Over our years of psychotherapy together, we have played many iterations of the same "game." Each time I have unwittingly passed the test, by remaining emotionally engaged and accepting of all of Gus without judgment or exploitation, his trust in me has increased. With each instance of additional trust has come greater safety for Gus to show more of himself to me, as he internally connects to more and more dissociated bits of emotion and self.

Here is the developmental picture as I came to understand it. Dating back to his early days in the womb, Gus had been emotionally traumatized. Gus's mother became pregnant by accident. She deeply resented giving up her own rising star as a jazz singer in order to care for a baby. Her rage and suffering during pregnancy worsened as all relations with Gus's biological father dissolved. Left alone, with the burden of an unwanted child, Gus's mother became physically and

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emotionally abusive during his early childhood, which continues in the form of emotional neglect to this day (Gus's mother is now in her 90s). The very core of this sensitive boy felt wiped out by his mother's self-absorbed, narcissistic ways. Fortunately, some of Gus's early terror was assuaged when his mother married a man who loved and adopted Gus a few years later.

In response to the abuse, Gus instinctively and quite literally hid from his mother from the start. In fact, his first memory, dating back to 3 years of age, consisted of fleeing from her by hiding in the hall closet. There he would cower in the farthermost corner, shaking at the sound of his mother's approaching footsteps, terrified of being beaten with a coat hanger. As Gus was hiding from his mother, he also started hiding from himself, by learning to split off and dissociate unwanted emotional pieces of experience. As a mature man, on the outside Gus seemed to be a highly rational, level-headed, accommodating person. Underneath, shrouded in isolation and mistrust, huge gaps blocked him from even recognizing his own vulnerability, hurt, or rage.

Before starting psychotherapy, 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 together 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.

As mentioned, Gus's sporadic transformation into Michelle 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 Michelle 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 (see Schore, 1994, 2012). Although Gus's two personalities inadvertently fit the stereotype of the rational man and the emotion-filled woman, my patient reported that Michelle's breadth and nuance of her emotional composition is extraneous to her gender. He also did not endorse such stereotypes in how he lived his life, in that Gus loved to cook and was incredibly warm, loving, and empathic to his own adopted son.

THE MUSIC OF PSYCHOTHERAPY

As the slow, steady work of psychotherapy progressed, Gus eventually made peace with his female side. He came to appreciate what Michelle had to offer him, which included reconnecting with the emotionally evocative music Gus used to compose but had given up after the death of his adoptive father. Toward the beginning of our work together, Gus wanted me to hear the last piece of music he had written 12 years earlier. The song, about a soldier whose job is to bag and send corpses home during a war, hinted at a hurt so deep that it could only be buried. The final measure ended with a long, arrhythmic gap between the last two words: "quiet" and "home." Gus had sung the composition only once, in a darkened recording studio, without any instruments, with his back turned away from the technicians. Following the recording, the song seemed too painful for Gus to bear listening; and no one else had heard the song since its inception.

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As much as Gus wanted me to experience his music, he was too terrified for either one of us to hear it. The CD recorder sat on the sofa beside him for week after week, until finally he was ready to hear the song again and witness his music's impact on me. This was a pivotal moment. The next session, Gus brought in a dream of being a pregnant woman wheeled down the hall toward the delivery room by a nurse. Gus protested, "I don't know how to do this!" while the nurse responded by soothing him/her and repeating over and over that everything would work out just fine. Indeed, Gus proved to be pregnant with song, allowing me to serve as midwife to his music. Twelve years prior, Gus experienced this piece of music as his first pregnancy, ultimately delivering something stark and shocking—a song that threatened to end all songs. But during this and subsequent stages of psychotherapy, once Gus's music returned, new melodies have poured out fluidly and prolifically.

Here is how Gus recently described his connection to music in his own terms (from Marks-Tarlow, 2015, p. 276):

> 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.
>
> 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.

In the quote above, we can detect the implicit structure of hide-and-seek in Gus's description of his own music as it simultaneously reveals the contents of his heart while disguising them. Eventually, in light of the lovely songs that began to emerge, Gus came to love his female side and the role Michelle played as muse.

One day, several years after the start of treatment, given his greater internal comfort, Gus speculated that perhaps we were ready to terminate our psychotherapy. Yet, he still felt confused about what full integration of his male and female sides really means, asking that day as he left, "Do I *have* to integrate?" To Gus, integration meant combining his two sides, which he could not imagine, given their differing emotional compositions and even body shapes. Meanwhile, in light of what happened next, Gus's explicit desire to leave psychotherapy proved only the start of the next round of hide-and-seek.

Next session, Gus entered my office with a huge cut on his forehead. He explained he had had a terrible car accident when driving his wife and son to celebrate a family occasion. As Gus turned left with an obscured sightline, his vehicle was hit on the passenger side by an oncoming car, causing it to roll sideways and land upside down. Gas poured out of the car, while the entire family negotiated an emergency evacuation through the roof. The accident had occurred miraculously outside the tower of a medical center. Fortunately, no one in either car was seriously hurt.

As he related this tale, Gus kept focusing on tiny details of what happened. Later, Gus admitted that this strategy helped him to split off and contain his emotion, so that he could make it through his account without "breaking down." During his story, Gus also emphasized over and over how lucky he and his family had been. Had the car been struck another inch in one direction, his wife surely would have been killed. As I listened to Gus's tale, I could feel my own insides

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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: I suspected he needed to cry.

The next time Gus and I met, he acknowledged I had been right about the crying. After reading details of the police report and seeing the photograph of the smashed car, Gus wound up convulsing into tears in the arms of his wife—the first time he had had such an experience with anyone. Later in the session, I asked Gus a rather unusual question, "Who cried—your 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 brought in a dream (from Marks-Tarlow, 2015, p. 277):

> 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 (Gus) 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. I start 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 as it related to the trauma of his car accident. The following week Gus made an announcement. The more he had thought about it, the more he became convinced that the dream was actually *not* about the car accident at all. Instead, Gus believed the dream revealed the relational territory of what takes place between us, as patient and therapist during psychotherapy.

Here is how Gus saw 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 him about why he didn't want to play with the toys. Internally, in his dream, Gus went through every possible answer, but just knew he was going to "lose." There was no way out. Gus described our game of chess as highly cerebral and exclusively defensive in nature. He set up strong lines of defense in order to maneuver and "block" my way in any way he could. Whereas my goal was to penetrate his defenses, his 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. The atmosphere has much been more open, undefended, and spontaneous. Meanwhile, this new round of hide-and-seek that began with Gus considering ending treatment eventuated in the emergence of yet a third personality, "The Boy," first evident in the play therapy dream. This previously dissociated aspect of self, what Bromberg (1998, 2006), after Sullivan (1953), would call "not-me," was a side of Gus so vulnerable and unwanted that he had no inkling of its presence until his dream. The Boy (which remains his name) is the repository of all the traumatic experiences Gus had ever had. Whereas Gus had come to appreciate Michelle for her lovely music and nuanced, enriching emotion, Gus

feared and wanted nothing to do with The Boy, who was so filled with rage and terror that Gus could not imagine bearing the pain, much less even conceiving of why he should try.

Whereas Gus was highly rational and deliberate in style, Michelle brought out the "high-right" capacity to feel intensely, to symbolize spontaneously, and to use imagination creatively, while The Boy seemed loosely related to a reptilian, subcortical, amygdala level of pure, primitive, unchecked emotion. In yet another iteration of self-similar theme, once again there appeared a huge gap between explicit and implicit agendas. On the surface, Gus wanted to end psychotherapy; underneath, another split-off aspect of self needed to come out of hiding and be revealed. Upon The Boy's emergence, our sessions felt like a repeat of the beginning of psychotherapy. Once again, Gus wanted to rid himself of inner, core experience; for now, Gus wanted nothing to do with The Boy, who remained tightly locked inside an inner closet.

One day, I suggested to Gus, "Michelle brings the emotions you want, while The Boy brings you the emotions you need." Gus responded with "Ouch!" When I asked what he meant by that word, he used his finger to draw a circle around his belly and chest, saying "Bulls-Eye!" Having previously pierced Gus's defenses, which were now lowered, we had previously switched from chess to a more collaborative stance. With Gus more openly vulnerable, he now felt pierced by the sharp pain of my suggestion, which his body language suggested felt more like a one-sided game of darts.

Then, the game switched again a couple of sessions later, when Gus declared us to be at an impasse. As he saw it, we were engaged in an intellectual form of sword-fighting. He and I were each approaching the other with dueling agendas. I was fighting for his sense of wholeness by rooting for The Boy to be incorporated into his being. Meanwhile, Gus rejected this agenda, both in mind and body, too terrified of being destroyed by The Boy, whom he didn't trust and still wanted nothing to do with. At that point in time, Gus didn't yet realize how much The Boy was feeling destroyed by him.

The impasse was broken subsequently through Gus's play of music. By writing a new piece, "Can't Find My Way Home," Gus found a way both to own and disown all three aspects of self simultaneously. Gus had been working on the composition for more than a year, which he described as the most "internal" thing he had ever written. The song kept changing forms, and especially endings. Meanwhile, as had become our habit, we listened to and discussed Gus's music in order to understand and slowly unravel complex emotions he could sense but not initially name. At this point in treatment, Gus could explore the realm of music quite thoroughly by shedding his outer body and quite literally travelling inside the music. Once inside, he could move in any direction, zooming into the tiniest of spaces, such as that between two notes or the point where notes collide with one another. As Gus spoke about his music, I too could visualize this synesthetic realm (see Cytowic, 1993) that ultimately translated to pure feeling.

"Can't Find My Way Home" contained all three of Gus's alters: (a) his rational, everyday aspect (Gus), (b) Michelle, and (c) The Boy. The piece was constructed like a fugue. The first iteration and presentation of its melodic theme was strongly and simply presented as a piano line (Gus's rational side). The second and third iterations introduced a wide range of harmonies, plus subtle variations in rhythm, tone, and volume as packed in by more than 30 stringed instruments (Michelle's highly nuanced emotional repertoire). The third iteration changed key and revved up in intensity, within which one can detect a very deep sound that is low in pitch and amounts to an atonal, arrhythmic thumping (The Boy's tantrums). In this final iteration, all three parts of Gus are battling it out. They descend toward chaos, out of which all the fragments eventually

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resolve into a single piano note, played three successive times, each time gradually slowing. The first two times, the notes are separated by an orchestral major chord. The third time, as the final note decays, it dissolves into an orchestral minor chord, becoming obscured and then completely hidden.

What an amazing representation of the history of our psychotherapy through music!

MAGIC IN THE RELATIONAL UNCONSCIOUS

From the start of my psychotherapy with Gus, I have been utterly amazed at synchronicities in the underground streams of transaction within our relational unconscious. The title of my previous paper in this journal, "Merging and Emerging," captured the full interpenetration of self and other that so often accompanies significant psychotherapy. Gus's dream about play therapy plus his subsequent declaration of its relevance to our relational dynamics arose just as I was musing on what to write for a chapter on the play of psychotherapy in the *Handbook of the Study of Play*. I don't see children in my practice, nor do I conduct formal play therapy. Gus had only a vague awareness of my writings on the subject of play. In this way, he penetrated my psyche so as to bring our work to the next level. Similarly, I felt equally able to penetrate Gus's psyche. When Gus talked about shedding his outer body in order to zoom into his music, he suspected no one, including me, would understand what he was talking about. Even worse, he feared sounding crazy. Not only could I picture what he was saying quite visually, but I also showed him a fractal zoom on my computer that aligned quite well with his inner musical travels. In these ways, the underground strands of our two lives kept entwining beautifully.

From my point of view, throughout the course of psychotherapy, Gus has unwittingly helped me to embody my own concepts about nonlinear dynamics, fractals, and interpersonal neurobiology. To encounter these concepts relationally has been exciting, helping me better to understand my otherwise quite abstract ideas. Meanwhile, Gus has the experience of being deeply understood. Whereas he started out feeling like an "extreme outlier," now he feels fully contained by my equally odd, outlier theories. My open, holistic, creative stance helps Gus to more fully own and embody neglected and scattered bits of self. I often surprise Gus by providing a positive counterpoint to his negative themes. Where Gus tends to perceive only gaps, conflicts, and the irreparable damage of a broken psyche, I tend to see ever greater instances of blending between alters plus fruitful dialogue across those gaps.

Just as Gus continues to bring his music into our psychotherapy as a means to reveal and review hidden dimensions, so too have I continued to bring in my writings about our work together as a way to reveal and review implicit dimensions of our work. Not only does this ensure accuracy, but it also furthers the work, often in surprising ways that prove illuminating to us both.

FROM ZERO-SUM TO WIN–WIN GAMES

Why do people seek out psychotherapy only to play hide-and-seek, when they are there of their own accord? 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 by pretending tender or vulnerable feelings don't exist. They then become too

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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 was to provide enough external, relational safety to reverse inner defenses.

What I had seen as a game of hide-and-seek had appeared initially 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 play 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.

Most recently, Gus has identified yet another of our games that represents the very opposite of hide-and-seek, which might be called "catch me if you can." The game consists of either the parent or the child saying "Try to catch me" and then running away. The chase begins. Obviously, the parent can always catch the child or allow themselves to be caught by the child. But the parent allows the game to go on for a period of time (either by not immediately catching the child or by not allowing the child to immediately capture them), then decides to end the game by catching or being caught. This is followed by rewards of hugs, kisses, laughter, and so on. It's a nonzero sum game, since the pursuer and the pursued both "win" when catching/being caught takes place. When the child is the pursuer, winning is catching the parent, but there's also a great paradox of the game in that when the child is being pursued, for the child, "losing" (being caught) is actually "winning."

This game—catch me if you can—is evident in the role Gus's music has played in our psychotherapy. Every time Gus says, "If you don't understand my music, you'll never understand me," it is his invitation to play. He then plays me his music, and the game begins. He talks to me about his music, which really is a safe, nonthreatening way to tell me about his internal, emotional self. This is Gus's way of running, yet knowing he won't and (for that matter) doesn't really want to escape. I listen to what he's saying and reflect it back to him, which amounts to the chase. By understanding Gus's music and thereby him, I catch, accept, and appreciate him, which amounts to the hugs. Game over.

But "catch me if you can" is also a reciprocal game. Whenever I hand Gus my writings to read and critique, I invite him to catch me, by catching sight of my most internal musings about him. Gus has pointed out the paradoxical nature of this deep level of interpenetration, which amounts to an uroboros (snake that eats its own tail/tale; see Marks-Tarlow, 2008; Marks-Tarlow, Robertson, & Combs, 2002): catching me in this way allows Gus to catch himself ever more deeply.

CONCLUSION

How and why psychotherapists and patients play together sets the emotional tone for sessions and determines the *feel* of intersubjective space. 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

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invitation to play is often a bid for connection that allows coordination, mutuality, and turn-taking. The more safety that 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 (see Marks-Tarlow, 2012a, 2014). This bold suggestion—to conceive of psychotherapy as more fluid than any reified theory or manualized treatment approach implies—is taken for granted by most psychoanalysts. Likewise, through lenses of nonlinear dynamics as well as the interpersonal neurobiology of play, this open-ended progression appears 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.

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CONTRIBUTOR

Terry Marks-Tarlow, Ph.D., is in private practice in Santa Monica, CA. Most recently she has authored *Clinical Intuition in Psychotherapy* (Norton, 2012) and *Awakening Clinical Intuition* (Norton, 2014). Along with illustrating her own books, she curates Mirrors of the Mind: The Psychotherapist as Artist plus edits the art exhibition catalogs. Dr. Marks-Tarlow is on staff with the Insight Institute and teaches developmental affective neuroscience at the Reiss Davis Child Study Center.

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