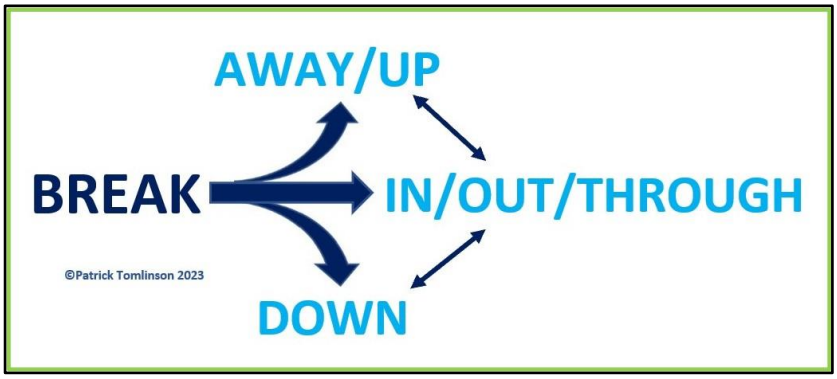
BREAK, BROKEN, BREAKDOWN, BREAKTHROUGH: MEANING AND COMPLEXITY

PATRICK TOMLINSON (2023)



Introduction

The word break and its derivatives are some of the more profound words in the English language. They can have meaning on deep levels in life. And additional relevance to some professions, such as mine, which might be termed the helping professions or human services. I am especially involved with trauma services where the words take on another layer of meaning. This article considers the complexity of such terms as break, breakdown, break-up, break-away, break-in, break-out, and breakthrough. How we use and think about these terms can have a profound effect on our lives and work. Often, they are used without much thought and with assumptions that can be unhelpful. This article aims to consider some of the meanings of the words and terms, and the dynamic relationship between them.

Break and Broken

The word break is commonly used to mean something snapping or becoming damaged under pressure. For example, the piece of wood snapped and broke. A broken bone or a fracture. Interestingly, being broke can also mean having no money. If someone says I am 'broke' that is usually what it means but it could also mean being broken emotionally. Break and especially broken tend to be viewed negatively. The word broken can be especially powerful and evocative, as in a broken heart, or broken-hearted; little is more poignant in the history of the arts and the depiction of human nature. However, it might also lead us to wonder what can be done to mend and repair what is broken.

Repairing and mending are vitally important to being human and provide meaning. They are less finite than fixing something. They suggest something ongoing rather than finished. This reminds me of the Japanese concept of Kintsugi - making something more beautiful by repairing what is broken. Our aim in life should not be an unbroken perfection but making the most out of imperfection. Kintsugi dates to the 15th century and means, "to join with gold". It helps us to

celebrate and accept our flaws. When something has been damaged, it has a history, and the repair can add beauty and strength.

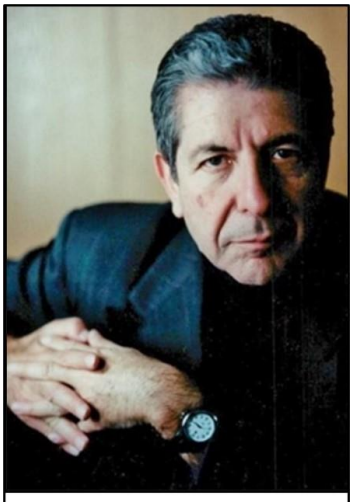


Photo by Ingvar Svensson, 1992

This idea of a broken or cracked vessel resonates with the lyric by Leonard Cohen,

"There is a crack in everything, that's how the light gets in."

Talking about this line in his song Anthem, Cohen (in Werber, 2016) said the situation "… does not admit of solution of perfection. The thing is imperfect… And worse, there is a crack in everything that you can put together: Physical objects, mental objects, constructions of any kind. But that's where the light gets in, and that's where the resurrection is and that's where the return, that's where the repentance is. It is with the confrontation, with the brokenness of things."

The word broken is often used to imply a highly negative situation. Such as, a system is broken. The system may be political, educational, health, legal, family, etc. Sometimes when this is said it is not clear when the system was ever complete or working. There may never have been a time when it was whole and working in the ideal, impossibly perfect way. Rather than be fixed or broken all systems tend to be in a constant state of change and evolution. So, being broken may be part of a process. I have heard people say that in the UK, for example, the education system is broken. My experience of school 40—50 years ago tells me that what is going on today is no more or less broken than it was then. It is different. We must continuously work to improve. Sometimes we might go backwards but I think language like broken is often melodramatic and unhelpful.

The word break is also often used to mean a pause between things, a break in the day, a break at work, or a break like a holiday. A short break, a long break, a permanent break. The break may be for negative or positive reasons. A planned break or a sudden break. Regular short breaks are usually seen as healthy and may help to prevent burnout or a breakdown. Phrases like taking a break or needing a break are part of everyday life. Interestingly, a planned break in continuity can help us to continue healthily, at work for example. The break can relieve the pressure that might be building up. If we need a break and either don't realize this or cannot take one there is a risk that the pressure causes a physical/mental break, such as an illness or accident. This may force a break away, temporary, or permanent.

Breakdown

The use of the word down along with break can feel ambiguous and unclear. The way we use the word break may be simple but at the same time evoke other associations. For example, if

we say, we are taking a break how might this be heard by someone who is preoccupied with break meaning breakdown? Breakdown and being down are often perceived negatively. However, it can be healthy to be down, and sometimes necessary for safety, as in to slow down. Slowing down may be good for health and well-being. On the other hand, being up can seem like being positive. There is a time for both and as is said, what goes up must come down. One young boy who had suffered huge amounts of trauma and loss stated,

> I don't need cheering up, I need cheering down.

He was tired of people telling him to cheer up - he needed to feel the depressing, sad, and painful things that had happened to him. He also needed adults to be with him while he felt his pain. As Black (1989) said,

> One needs to walk through the pain, not over it, not around it.

This can be difficult for adults whatever their role. And they may also find there isn't enough attention to their difficult feelings. We must get a balance - if difficult feelings cannot be felt, acknowledged, and thought about together - what happens to them? where do they go? Being able to feel down and stay with the feeling is a developmental achievement and essential for mature health, referred to as the depressive position (Melanie Klein). Trauma can be considered in general as a break. Winnicott (1963a, p.97) described trauma in early infancy as a reaction,

> … to unreliability in the infant-care process constitutes a trauma, each reaction being an interruption of the infant's 'going-on-being' and a rupture of the infant's self.

The same could be applied to trauma at any point in life – as something which interrupts a person's going on being. When we experience a trauma, in this sense, what we need is to be understood in a way that helps us integrate the traumatic experience. For example, an infant who is experiencing trauma in the way Winnicott describes needs to be met by a responsive caregiver. This enables the infant to feel emotionally and physically held. Whatever it was that felt unbearable has been felt by another who has transformed the experience into something survivable and possible to make sense of. When a traumatic situation is not responded to in this way and either ignored or reacted to, it cannot be integrated as an experience but remains fragmented and split off.

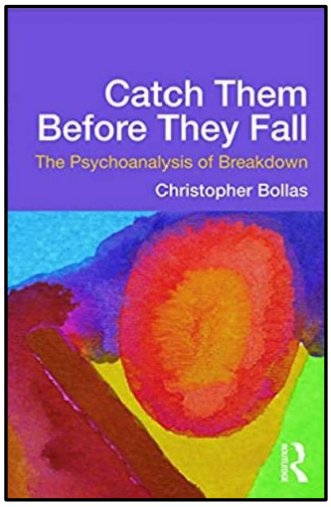
When another similar situation arises along with an increased fear of not being understood, the new situation has the potential to be integrated along with the split-off fragments that are associated with it. This may be a reason why traumatic issues are recreated. It may be a search for the integration and potential transformation of previous fragmented, unintegrated, and split-off experiences. When trauma is repeatedly not met with a holding and containing

response - the fragmented, unintegrated, and split-off experiences accumulate. This is when someone might become traumatized.

Breakdown conjures up fear of something awful. Such as a mental breakdown. Or, a breakdown of functioning, something not working. Like a broken-down car which needs a breakdown recovery service. No one ever says they need a breakdown, though the consequences can be life-changing in a positive way. For example, a 'mental breakdown' is a crisis, and a crisis is an opportunity. The ancient Greek word 'krisis' means to distinguish, to choose, to decide. Crisis, the Latin derivative meant a turning point in a disease. The breakdown or crisis may be a necessary part of change and growth. It is not necessarily a failure, and it might be that not being able to have a breakdown or crisis is a worse situation. Fosha (2003) describes the therapeutic potential that a crisis presents,

> Crisis disrupts defenses; in this case, the crisis unraveled the organization of the preoccupied state only to reveal the underlying tendencies toward attachment disorganization. But because it disrupts defenses, crisis can be a major transformational opportunity (Lindemann, 1944), if the individual is supported through it.

While a crisis may be an opportunity, we should not underestimate the potentially devastating consequences. In his book, *Catch them Before they Fall: The Psychoanalysis of Breakdown*, the pioneering psychoanalyst Christopher Bollas (2013) wrote about the transformative potential of working through a breakdown situation. A description at the beginning of the book, says,



"He (Bollas) suggests that the unconscious purpose of breakdown is to present the self to the other for transformative understanding; to have its core distress met and understood directly. If caught in time, a breakdown can become a 'breakthrough'. It is an event imbued with the most profound personal significance, but it requires deep understanding if its meaning is to be released to its transformative potential."

Bollas (p.5) states the consequences when a breakdown is not met effectively,

> The outcome of a breakdown is not necessarily a descent into psychotic decompensation, although this may occur. More commonly, people who suffer a breakdown, which is not transformed at the time into a breakthrough, become what I term broken selves. They then function in significantly diminished ways for the remainder of their lives.

Bollas (p.16) describes some of the characteristics of being broken,

> A broken person is characteristically indifferent to their life. They are passive and resigned to their situation… Their indifference may be accompanied by unrealistic plans—writing a novel, becoming an entrepreneur—but no actions are taken towards accomplishment in their field of dreams. Instead, these plans function as projections of the broken self: broken dreams that exemplify the impossibility of success… The broken person's affect is significantly reduced. They rarely show emotion and are not driven to anger, anxiety or euphoria by events in life. Instead, they maintain a steady remove from affective shifts; nothing is worth the effort.

As Pascal and Vernon (2022) state, there is hope,

> … if we can find a container that enables, as Donald Winnicott the British psychotherapist rather wonderfully put it enables you to go to pieces without falling apart then there might be a breakthrough on the other side of that. But you've got to be able to have space for what can feel combative, what can feel aggressive, what can feel even destructive or desperate in a moment.

Fear of Breakdown and the Breakdown that can't be Experienced

The idea of breakdown can naturally evoke fear. The extent of being out of control, suffering pain, and potentially awful consequences are real. Fear of breakdown may also be connected to a breakdown that has already happened but not consciously remembered. This fear may be held in the body and experienced physically, through anxiety, panic, pain, and other sensations and symptoms. Sometimes, these feelings may be managed by shutting off from feeling, with the consequence of being disconnected from one's body and feeling deadened (Ogden, 2021). Bessel van der Kolk (2014) summarizes this well with his book title, "The Body Keeps the Score". He acknowledges the long history in the field of psychology, of understanding the link between body and mind. He states,

> The names of some of the greatest pioneers in neurology and psychiatry, such as Jean-Martin Charcot, Pierre Janet, and Sigmund Freud, are associated with the discovery that trauma is at the root of hysteria, particularly the trauma of childhood sexual abuse. These early researchers referred to traumatic memories as "pathogenic secrets" or "mental parasites", because as much as the sufferers wanted to forget whatever had happened, their memories kept forcing themselves into consciousness, trapping them in an ever-renewing present of existential horror.

Joyce McDougall built upon this early work with her ground-breaking book, "Theaters of The Body: A Psychoanalytic Approach to Psychosomatic Illness". She (1989, p.28) points out that,

> The body, like the mind, is subject to the repetition compulsion.

The understanding of the body-mind connection has developed further through the work of Pat Ogden among others, who have developed a sensorimotor approach to psychotherapy and the healing of trauma. Ogden (2021) claims that,

> Hope lives in the movement vocabulary of the body.

In this context, the fear felt may also be a way of keeping the memory alive so that it may become integrated. Hope and fear may be part of the same situation. In, "The Experience of Breakdown and the Breakdown that can't be Experienced: Implications for Work with Traumatised Children", Tomlinson (2008, p.15) argues,

> The concept of breakdown is often perceived negatively, and this can dominate our response. However, with an informed approach, a breakdown can be seen as an opportunity for growth and a point of healing.

In this paper, I highlighted some of Donald Winnicott's (paediatrician and child psychoanalyst) thinking about breakdowns and the theme in the lives of traumatised children. As well as breakdowns in their family life these children are often placed in care situations which go on to breakdown and lead to many moves which continuously reinforce a negative pattern of breakdown. Tomlinson (2008, p.15-16) states,

> From my experience of working in therapeutic residential settings for traumatised children, who have suffered emotional, sexual and physical abuse, it can be safely said that by the time these children arrive in such a place, they will have experienced multiple placement breakdowns. These breakdowns are often catastrophic in nature and prolific in their frequency.

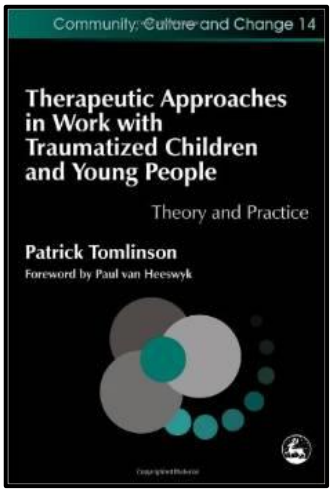
These very real and tangible breakdowns are hugely damaging and extremely difficult to recover from. What can be even more difficult to recover from are the less tangible breakdowns, of which there is no conscious memory, but which are stored in the body like a haunting reminder of something awful, which is felt but not known. Two of Winnicott's papers are especially helpful, 'Fear of Breakdown' (1963) and 'The Psychology of Madness' (1965). He explains (1963) that if someone had a breakdown early in childhood but was unable to experience and integrate it into their history – he may seek the breakdown that has already happened in the present so that it can be experienced, survived, understood, and integrated. It will then become a conscious memory. Feeling the breakdown that cannot be remembered is most unbearable and what the person seeks relief from. Winnicott (1963, p.92) refers to these feelings as primitive agonies and he says,

> The only way to ''remember'' in this case is for the patient to experience this past thing for the first time in the present, that is to say, in the transference. This past and future thing then becomes a matter of the here and now, and becomes experienced by the patient for the first time.

The way the search for a contained and transformational experience of a breakdown manifests itself can take different forms. Such as a fear of death, a breakdown in health, a breakdown in the environment, and a relational breakdown. Winnicott says, for example, that a fear of death may be a compulsion to look for the death that has already happened. He states (1963, p.91),

> In other words, the patient must go on looking for the past detail which is *not yet experienced*. This search takes the form of a looking for this detail in the future.

The breakdown cannot be let go of and put into the past until it is experienced and managed in the present. If those involved in a breakdown situation can safely survive, this could be the most important turning point in the life of the person having the breakdown. In this type of situation, it can be argued that the experience of breakdown is needed as part of recovery. However, helping someone through this can be testing to the extreme. The person who is compulsively looking for a breakdown is also terrified of it at the same time. And when there is nothing conscious to link this to it can feel bewildering and 'mad' to the point of seeming impossible and unbearable. This must be close to what the person felt at the time of the original breakdown. If this all works out well the breakdown may be a turning point that feels like a breakthrough. Explaining this approach in the context of therapeutic work with children and young people who had suffered developmental trauma, Tomlinson (2004, p.137), said,



"Therapeutic work with traumatized children will involve work on what is absent, missing and lost. For example, the absent parent or the move away from home, or in some cases many moves from many homes. Whenever there is an experience of absence or a break in our work with traumatized children, we can expect to work with it in terms of the here and now, as well as in the context of the past. Therefore, absences and breaks provide difficulties to work through in the present, which are compounded by the child's past. This can make absences and breaks seem like an unhelpful disruption to treatment. However, as trauma is often associated with absences and breaks, working through these issues with the child is part of the recovery from trauma."

Break-ups, Breakaways, Break-ins, Break-outs, Breakthroughs, and Boundaries

The term break-up is often used in a relational context but can also be used in other ways. For example, the break-up of the Soviet Union, or the breaking up of a negative pattern. It can imply that something whole is broken into pieces. It implies separating something into parts. A break-up may be neither negative nor positive but a different and new situation. The break-up may be a point of growth. Not always an endpoint but the beginning of something new. It may also be temporary and what is broken up may be made up again. A break-up may lead to a breakdown, breakthrough or vice-versa. A breakaway may help prevent a break-up by providing space in a difficult situation. A breakaway seems less definite than a break-up. People often return after a break away.

Similarly with break-ins. It is usually a negative term, as in a burglary. A violent, forced, and delinquent entry. However, it can also have relatively neutral meanings, such as breaking-in a new pair of shoes, or positive meanings like a break into a new market. Or breaking into something difficult to get into. Like making progress by breaking into a closed system. Breaking in can mean disrupting a norm. In this sense, breaking in is like breaking through.

The word breakthrough usually has a positive meaning. For example, a breakthrough in science, or a breakthrough in overcoming a big obstacle or challenge. A breakthrough may come after a prolonged period of hard work and is often admired. On the other hand, it may happen by getting a 'lucky break'. A breakthrough suggests a radical change. Pascal and Vernon (2022), explain how a breakdown may disrupt homeostasis and through a supported transition, lead to a richer new situation. While it may seem positive, there may be unexpected consequences of the breakthrough. For various reasons, progress may be resisted and attacked. Time is needed for the change to be processed. The change also involves the loss or adaptation of previously held ideas and beliefs.

The impact of the change may lead to negative reactions, which could undermine or setback the breakthrough. In therapeutic work, the term negative therapeutic reaction is used to describe how what seems initially positive can lead to a negative reaction (Barake and Ferro, 1992). For example, this is too good to be true, so I better ruin it before someone else takes it away, and I don't deserve this. If sudden progress is made, the unfamiliarity of the new situation and uncertainty of the future may cause anxiety and potentially worrying possibilities. I have known young people who have made progress in recovering from trauma to suddenly revert to earlier negative behaviour. Some have been able to say, they felt they would have to leave and move on if they got better. Progress may also mean more responsibility, freedom, and choice, which all have their difficulties. In other words, a potential consequence of progress can be fear.

Break-out may seem to be the opposite of break-in but the reality can be more complex. Like a break-in, a break-out can also be a forceful and delinquent transgression of a boundary. For example, criminals may break out of prison. Wars, hostilities, and riots are said to break out. And when they do the effect can be contagious. Break-out can also be used to describe a break-out of an illness, like a contagion or a break-out of acne. These examples also evoke something about a boundary being broken or fragile.

The term can also be used to mean separation and differentiation, for example, to break out of a mould or to break out of a large group into a small group. Again, there is an issue of boundaries. It could be argued that many of the issues connected to break and the related terms are strongly connected to boundary issues. Too permeable or fragile boundaries and too rigid boundaries may provoke, some of the dynamics I have discussed. In her seminal book, *Trauma and Recovery*, Herman (1992) discusses how boundary violations are common in the histories of patients who seek therapy because of mental illnesses. She also makes it clear how further boundary violations are always a risk in

the therapeutic process. This can be thought of partly as trauma reenactment. Referring to the difficulty of the work and what is needed, she says (p.147),

> Traumatic transference and countertransference reactions are inevitable. Inevitably, too, these reactions interfere with the development of a good working relationship. Certain protections are required for the safety of both participants. The two most important guarantees of safety are the goals, rules, and boundaries of the therapy contract and the support system of the therapist.

She adds (p.149),

> Careful attention to the boundaries of the therapeutic relationship provides the best protection against excessive, unmanageable transference and countertransference reactions. Secure boundaries create a safe arena where the work of recovery can proceed. The therapist agrees to be available to the patient within limits that are clear, reasonable, and tolerable for both. The boundaries of therapy exist for the benefit and protection of both parties and are based upon a recognition of both the therapist's and the patient's legitimate needs.

The same principles apply to any breakdown and to anyone who is trying to assist with such a difficult situation. As Herman says, attention must be paid to the legitimate needs of all who are involved.

Conclusion

The terms I have discussed tend to evoke assumptions. These assumptions may differ and be personal. For instance, we may always tend to be fearful of breakdowns and hopeful about breakthroughs. However, it may be helpful to keep an open mind and see the positive and negative possibilities in both as well, as in the other terms described here. Rather than being separate the terms discussed here are often interrelated. The relationship is dynamic and fluid rather than linear and fixed. If we keep this in mind we might reap the potential for repair, healing, and growth involved in these challenging processes.

Comments and Acknowledgements

Before writing this article, I shared an early version of the Break diagram and asked for feedback. The authors below have kindly agreed for me to share their comments, which I think add greatly to the article. I especially find the questions they ask to be thought-provoking. I would also like to thank Dr. John Gibson and John Whitwell for their helpful comments which helped me elaborate on the diagram.

Helena Moore – Psychotherapist and Director of Practice at MASP, Victoria, Australia

This is a lovely metaphor. The comments you go on to make about systems repair remind me of our conversations about affecting organisational change – too much "comfort" prevents necessary growth. Of course, Winnicott would say that a good parent will be imperfect and that human beings (both parent and child) need the right amount of challenge to progress.

Today I was working with a man in his forties who recently became homeless. After 6 years of living as a recluse with a fear of going out, he stopped paying his rent and was evicted. As we explored his options, he told me that he had felt "trapped" by his abusive parents as a child. In speaking about it, he gradually came to feel some sense of pride (I think), in getting on "out in the world". Is this an example of "seeking the breakdown that cannot be remembered"? Furthermore, once he "remembered" he was able to accept the support that he had up until now stubbornly refused. A very interesting connection! One that I had not thought of until I read this article.

I think about the sensory body here too – a "breakthrough" must be "felt" and integrated, this takes time. I am thinking of Pat Ogden's work where she talks about traumatic "wounding" – (I also often think of Esther Bick's work on psychic skin).

Drew Garner – Senior Leader of Health Care Services, Queensland, Australia
The word breakdown to me implies something finite. Which it's not. Just my feelings on it.
It is interesting to consider what these words might mean. Language is so powerful as we all know. It sets the tone for what is to come. If you're trying to capture the opportunity, then maybe the whole process needs to be thought about. With breakdown really what's taking place is a system being overwhelmed, unravelling faster than we can process.

Jane Keenan - Author & Provider of Professional Development, London, UK
In this context - the image - I associate 'break' with 'fracture'.
In work with children in care, a breakdown has been considered bad, and a breakthrough has been considered good, but I'm not comfortable with either… something too brittle about each, or too definitive… something has been broken… did something need to be broken to achieve breakthrough…? Too splitting. I haven't reflected on and examined these terms, but feel there are better options for a notion of a positive 'breakthrough'… growth, penny-dropping, resolution, realisation, shift…?

And breakdown used to describe an unplanned ending… also too simplistic, and too definitive… not recognising of the breadth and depth of why an ending might come about, and does an ending have to mean irrevocably broken?

Sean Williams - **Director at Birch Insights, Worcester, UK**
I also associate the link between break as in break time and recreation - re-creation. I sense that links with your diagram - coming into parts/fragments/realisation/transition/(break-up breakdown) support a change/development/transformation. (Break-in/breakthrough) life is a constant flow of experience and meaning and we can get stuck in cycles/patterns/eddies that we need to be released from. Courage is key, I think.

Re break-in… We do seem to 'relate' from closed boundary survivor roles that may require a dissolving, breaking into and out of for life to progress and be experienced anew. Perhaps there are many roles or layers, or neural networks that protect us. So, there is a constant sense of

'undoing' and 'remaking' ourselves concerning who we were, who we are, and who we can be in the widest range of contexts.

…

A few thoughts to add - not in any expert way - just playfully integrating various ideas.

I am currently very curious about how the states outlined in the polyvagal theory relate to break down/through/in/up/away…

Dorsal vagus activation - shut down, dark gloomy helpless, shamed, foggy - perhaps a state of breakdown to be broken into (by another) or out of? Sometimes protective shells need to be cracked open with help? Maybe? Does moving through this dorsal vagal state into Sympathetic activation - fight or flight and the associated energy that brings possibility lead to a sense of break up and breakthrough/ break in/ break away?

From here we could fall back into dorsal vagus activation again - a breakdown (down the hierarchy) or continue to move up the hierarchy and on into the possibilities that go with the social engagement system and all its colours and connections to life - passion, energy, experience and exploration, flow, free. A break-in and breakthrough?

As the Polyvagal Theory is hierarchical - and explains that our nervous system is primed for protection (defences against connection) or connection (open engaged, safe, alert) I wonder if the words and metaphors and representations in psychoanalysis relate intuitively to these three (and some blend of the three) neurological states? Up and down, in through and out?

Exciting and interesting discoveries I sense… Our flexibility, neurological and psychological is said to be our ability to cycle through these states and is seen as a sign of health (resilience?)

Is this what we are trying to do in our relational work with children who are 'stuck' (need help to break out of or into unfamiliar neurological states) in ventral vagal, sympathetic or dorsal vagus (shutdown) states? Places where we get stuck and repeat - no new information in-nor out from here.

Do we as practitioners use our nervous systems to titrate, lead, follow, and partner a child in and out, through and away from these defensive states so that they can take on and take in the capacity to experience all of these states whilst remaining anchored enough in the grounded and centred space that love, nurture, care, play - secure attachment - brings.

Wonderful to share ideas like this…

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THE EXPERIENCE OF BREAKDOWN AND THE BREAKDOWN THAT CAN'T BE EXPERIENCED: IMPLICATIONS FOR WORK WITH TRAUMATISED CHILDREN

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Abstract

In this paper, I shall write about the significance of breakdown in the lives of traumatised and abused children. I will highlight the implications for those attempting to provide treatment for these children, potentially enabling them to recover. I also hope to demonstrate how important it is to have a conceptual framework, which I think must be underpinned by sound theory. The concept of breakdown is often perceived negatively and this can dominate our response. However, with an informed approach, a breakdown can be seen as an opportunity for growth and a point of healing. By applying a theory of Winnicott's I will show how useful and relevant, established theory can still be in our work. In particular, I will show how Winnicott's distinction, between the breakdown that has been experienced and the breakdown that has happened but not been experienced, is relevant in work with traumatised children.

I will be writing primarily about severely traumatised children placed in a residential setting, where the aim is to provide recovery and to do this by broadly working within a psychodynamic approach. However, many of the ideas described in this paper may also be relevant to those working with children in other settings, such as foster families as well as with adults where a breakdown is a theme.

Keywords Breakdown, Trauma, Children, Treatment, Recovery, Winnicott

> It may be a kind of loving but often it has to look like a kind of hating, and the key word is not treatment or cure but rather it is survival. If you survive then the child has a chance to grow and become something like the person he or she would have been if the untoward environmental breakdown had not brought disaster (Winnicott, 1970, p.228).

The Theme of Breakdown in the Lives of Traumatised Children

From my experience of working in therapeutic residential settings for traumatised children, who have suffered emotional, sexual and physical abuse, it can be safely said that by the time these children arrive in such a place, they will have experienced multiple placement breakdowns. These breakdowns are often catastrophic in nature and prolific in their frequency. I have known a seven-year-old to have had over fifty placements. The reality of this must be incomprehensible to the child. The norm for a child beginning a placement where I work is six placements in the last two years.

The following statement found in a child's history synopsis is sadly typical.

Joe, 9 years old, joined his permanent foster family in February. In March he was told they

could not cope, and he would have to move into a short-term family. This was after five placements in the previous two years. Joe has developed an extremely distorted sense of what 'permanent' means. Joe was then placed in a residential therapeutic setting. A year or so later, after settling down in his new placement, beginning to feel safe and engaging with the therapeutic work, his social worker states that his 'Auntie Kath' will be able to look after him. He was just beginning his recovery and was also making good progress at school. Joe was told he would be moving to his Auntie's two months in advance of his move. He seemed stable during the first month, but deteriorated after that and following some aggressive and sexualized behaviour, his Auntie informed the social services the placement must end.

It is not difficult to see how children like Joe, who have suffered massive breakdowns in the continuity of his care, often from birth onwards, will have internalised the reality that everything ends in a breakdown. Nothing lasts, promises mean nothing, and adults cannot be trusted - they say one thing and do another. Breakdowns are familiar and, in this sense, provide the only certainty in these children's lives. The familiarity of breakdown is safer than the vulnerability that comes with hoping that things will work but with the risk of being let down again.

Breakdown that has been experienced

When an infant has experienced positive primary provision from his carers to meet his needs, he has developed a sense of a world and his place in it. From this position of security, he can also know when things go wrong. For example, if one of his parents becomes ill, or if there are sudden abrupt changes around him. A child who has experienced 'good enough' provision, which is then lost, can be called deprived. He is deprived of that which he once had, which has now been lost. It is not surprising that such a child may begin to look for what has been lost and if it does not turn up, begin to provide for himself a symbol of what has gone. This could take the form of self-provision (of food for example), delinquent excitement, stealing, or all three!

Freddy who thought he could drain the life out of people

Early in my career, working with traumatised children I was given the task of residential key carer to a ten-year-old boy, Freddy. Not long after his arrival, he informed me with a manic look of glee on his face that he would 'drain the life out of me'. The power of his communication was disconcerting and I wondered if this child really could do this to me. Reflecting afterwards with the staff team, we drew our attention to the reality that three foster mothers in his last three placements had all suffered 'nervous breakdowns' which led to placement breakdowns for Freddy. He felt responsible for these breakdowns and believed that the impact of trying to care for him would drain the life out of anyone who tried it. Now that this had formulated in his mind as to what would happen, he was determined to try and make it happen. Taking control in this way would be safer for him than hoping that someone really could stick with him, only to suffer further rejection.

By the time a child such as Freddy ends up in the care system, he will have experienced major and minor breakdowns in the early years of his life, within his own family. The major breakdowns may include, the death of a parent in turbulent circumstances; sudden changes

such as the prolonged absence of a parent; actual emotional breakdown within one of the parents; physical and sexual abuse. Minor breakdowns could be described as the ongoing lack of parental attunement to the child around the minutiae of ordinary, daily life. For example, if the primary carer is not attuned to their infant child, perhaps as a result of their own depression, the child's primary needs will not be met. The infant's reaching out may not be noticed, so the infant may perceive the world around him as unresponsive, uncaring or even hostile and attacking. This can happen within a context that does not appear to be an explicitly abusive or turbulent environment. To the infant, repeated failure to respond appropriately to his needs can be a catastrophic breakdown. He has no internal resources to manage this failure or even experience it. At the worst extreme, the child may become completely shut off and appear 'emotionally frozen' (Dockar-Drysdale, 1958, p14-27).

In working with severely traumatised children, we are now familiar with the concept of 'testing out'. We expect these children to test us out, normally following a 'honeymoon period'. If a newly placed child is not testing us out we wonder when it will begin, but we always expect it. The commonplace understanding of this is that these children have experienced failure, breakdown and rejection so much that they can no longer trust anyone. We say we won't give up on them, but they've heard it all before. Will our actions continue to reflect our words if they show us how unlovable and nasty they feel they are? This seems rational and mostly we can empathize with the child's need to test us in this way. By surviving the test the child may experience us as safe and reliable and can gradually begin to trust and move on from the need to test us in this way.

Jack who tried to provide for himself

This case example comes from my work with emotionally disturbed children in a residential therapeutic setting. The children I worked with had all experienced severe deprivation during infancy.

> That is to say, there had been a loss of something good that had been positive in the child's experience up to a certain date and that had been withdrawn; the withdrawal has extended over a period of time longer than that which the child can keep the memory of the experience alive. (Winnicott, 1956, 309)

Winnicott (Ibid, 313) goes on to point out that when this deprivation takes place in early infancy, and it is a 'good' experience that has been lost,

> …it is an essential feature that the infant has reached a capacity to perceive that the cause of disaster lies in an environmental failure.

In his paper, The Antisocial Tendency (1956), Winnicott describes in some detail how the treatment of this environmental failure must also come from the child's environment as a whole. Because of this, any 'localised' form of treatment, such as psychotherapy, will only work if the child feels all aspects of the environment are responding to his needs. Winnicott argues that when the deprived child experiences a sense of hope in the environment's capacity to

recognise and meet his needs, he may well develop antisocial behaviour, such as stealing or destructiveness that has a high 'nuisance value'. If treatment is to be successful, the people that make up the child's environment will need to consider his antisocial behaviour as a sign of hope, whilst they also attempt to safely manage the child and sensitively consider matters such as 'right and wrong'.

This theoretical background provides the context for a situation that arose in the treatment of Jack. After what appeared to be a reasonable first year of his life, where his mother expressed pride and affection towards her baby, there was a rapid deterioration when his mother became pregnant by a new partner. Her partner was violent towards her and she suffered from clinical depression. By the age of three, due to the extreme instability of parental care, Jack was taken into care by the local authority. His first placement breakdown was at four years and many more followed. He displayed challenging and aggressive behaviour. This antisocial behaviour was neither tolerated nor understood. If there was an element of testing out to see if he could be safely and reliably contained he found out that he could not. The result of this pattern will increase the child's anxiety that he is not safe, and his needs cannot be met. Every time he feels at all hopeful we can expect his 'testing out' to increase. By the age of eight, after fifteen placement breakdowns, Jack was placed in one of our residential homes. His father was in prison and his mother had died of alcoholic poisoning. In our work with Jack, his behaviour became extremely testing, mainly through challenging and aggressive behaviour. We had to survive this, both emotionally and physically, whilst continuing to ensure that our provision remained reliable.

Children like Jack often expect to be completely rejected as soon as they show difficult behaviour, to have all good things taken away and to be severely punished. Just after a year into Jack's treatment, he began waking in the night, sneaking into the kitchen and taking biscuits. When this was discovered by his key carer, it was taken to a team meeting for discussion rather than reacted to. Jack had just begun to establish a relationship with his key carer and it was felt that this behaviour might show that Jack was looking for provision and like many deprived children, was looking to provide for himself what really should be provided within the context of an attachment with a reliable carer. As Dockar-Drysdale (1969, p.63) argues, 'but the food, in my view, should always *be given by somebody,* rather than be collected by the child from the larder'. The hopeful aspect was that he had alerted us to this. We decided his key carer should suggest to Jack that he might like a special drink and favourite biscuit from his carer at bedtime. Jack eagerly agreed and enjoyed this experience reliably for the next two years without ever going to the kitchen in the night again.

Children, who have experienced breakdowns, will need to re-establish a sense of safety so that they can receive the provision which will fill the gaps left by their deprivation. They need to create circumstances similar to the breakdowns they have already experienced, to find that they can be safely held through this and not rejected. It is when things get difficult that these children expect everything to go wrong. In their early life, there was a stage where things were 'good enough', but when things began to go wrong, the outcome for the child was disastrous. So, these children are used to good intentions and know that people will be caring towards

them when everything is going well. It's what we will do when things are not going well that they want to know about. Freddy knew I would care for him as long as he behaved himself, just like his previous three foster mothers had all said how they would look after him until he was grown up. Then he got difficult and 'drained the life out of them' - they got ill and got rid of him.

Rather than swing between idealized hopefulness and despairing hopelessness about the work involved in looking after children like Freddy and Jack, it is important to be able to hold both aspects together. However, this is difficult to maintain when it comes to the reality of the long, arduous and often painful work involved in a child's recovery. If those involved are unable to accept their ambivalent feelings towards the children as part of their work, they will likely protect themselves and the children from these feelings by splitting them off and projecting them elsewhere. For example, instead of feeling and being able to recognise hateful feelings towards a child, they might project it onto his social worker, parents or other professionals. All of these may be blamed or criticised aggressively. Unfortunately, the denial of ambivalence in the actual work with a child will only reinforce his inability to contain ambivalent feelings, making any progress in his treatment very unlikely. Before long, the tensions involved in maintaining this situation would probably lead to a breakdown in his treatment and placement.

Breakdown that has happened but not been experienced

There is a kind of breakdown and consequence of breakdown that has not found its way so successfully into mainstream thinking. This is the kind of breakdown that has happened but not been experienced because the child or infant had not reached a point of development whereby he could experience it and lacked the external support needed to help make his experience comprehensible. It is one thing to experience something awful, which can be thought about and comprehended to some extent. It is quite another for an event to happen, which is so awful that it cannot be thought about as an experience. For example, we may experience massive shocks, which we can nevertheless be consciously aware of and think about when we are ready. There may be another kind of shock which is so great and overwhelming that we cannot experience it. As a result, we may shut down and blank out from reality, partly to protect ourselves. From the perspective of a 'healthy' adult, it is challenging to imagine how terrifying, and unimaginable the shock would have to be. It is however probably not beyond our ability to conjure up some sort of catastrophe that could send us into such a place.

So, for a newborn baby or infant, who has little internal emotional resources, what kind of shock or breakdown, is so awful that it is completely beyond their comprehension? It is possible to imagine that the kind of deprivation and abuse suffered by children discussed in this paper, may fall into this category. This kind of 'happening' if it cannot properly be called an experience, can only be felt later on by the child or adult as something being there, somewhere, which just feels like dread, fear, and panic lurking in the background, constantly threatening to overwhelm. Whilst this feeling may be pervading and familiar, the person will not be able to link it to anything, as it has never been comprehended, thought about or understood.

In this section, I shall be drawing on Winnicott's ideas expressed in his two papers, 'Fear of

Breakdown' (1963) and 'The Psychology of Madness' (1965). These papers refer to this type of breakdown, which has led to the 'reversal of the individual's maturational process'. Winnicott (1963, p.92) explains,

> The purpose of this paper is to draw attention to the possibility that the breakdown has already happened, near the beginning of the individual's life. The patient needs to ''remember'' this but it is not possible to remember something that has not yet happened, and this thing of the past has not happened yet because the patient was not there for it to happen to. The only way to ''remember'' in this case is for the patient to experience this past thing for the first time in the present, that is to say, in the transference. This past and future thing then becomes a matter of the here and now, and becomes experienced by the patient for the first time.

Elaborating on what this breakdown feels like, Winnicott (ibid, p.89) uses the term 'primitive agonies' and compares these to psychotic anxieties such as 'disintegration' or a 'lack of relatedness' (1965, p.127). As this breakdown has not actually been experienced, and therefore cannot be consciously referred to, but has had such a powerful effect that is felt by the person so that there is an awareness of something being there, Winnicott (1963, p.91) argues that the person will express or show something that can be connected to the breakdown – such as an illness.

> In other words the patient must go on looking for the past detail which is *not yet experienced.* This search takes the form of a looking for this detail in the future.

He continues,

> … the original experience of primitive agony cannot get into the past tense unless the ego can first gather it into its own present time experience and into omnipotent control.

Given the disastrous nature of the breakdown, we can imagine how this might lead to a fear of death,

> When fear of death is a significant symptom the promise of an after-life fails to give relief, and the reason is that the patient has a compulsion to look for death. Again, it is the death that happened but was not experienced that was sought. Death, looked at in this way as something that happened to the patient but which the patient was not mature enough to experience, has the meaning of annihilation (ibid, p.93)

Winnicott (ibid, p.93) argues that the failure of the facilitating environment, causing interruptions to the infant's ongoing sense of being would be a kind of death. Traumatised children who show this extreme level of fear, may do it in ways which are not directly related to death fears but are extreme, both in the intensity of the child's behaviour and the feelings this evokes in others. For example, Winnicott states,

> In practice the difficulty is that the patient fears the awfulness of emptiness, and in defence will organise a controlled emptiness by not eating or learning, or else will ruthlessly fill up by a greediness which is compulsive and which feels mad. The basis of all learning (as well as of eating) is emptiness. But if emptiness was not experienced as such at the beginning, then it turns up as a state that is feared, yet compulsively sought after (ibid, p.94).

Winnicott's phrase, 'which feels mad' is telling. Whereas Freddy had some conscious sense of breakdowns that had occurred in his life, a child who has not experienced breakdowns that have happened will have no links to those experiences and can only show us the experience in ways that feel mad or incomprehensible. Freddy directly made me feel anxious that I would have a breakdown. How he did this enabled an immediate link to be made with the breakdowns he had experienced. It then became possible to begin to think about this with him. The work would still be extremely demanding and testing until Freddy could internalise a new experience where things did not break down.

Nigel who didn't know what he wanted, but there was never enough

Nigel was six years old when he joined us. His experience in early infancy had been so severe that it would more accurately be described as privation rather than deprivation. He had not had anything 'good enough' of which he could then be deprived. He joined us at a younger age than most referrals, mainly because his behaviour was too extreme to be managed in a foster care setting. Within a short period, he had overwhelming panics, and he would need physical holding by at least two adults, to ensure he was safe. The panics seemed to come at almost any time without any obvious triggers. He had no words to describe his feelings before or afterwards. When he was in a panic he would scream, kick, hit, spit and bite. Most of his words would be foul and abusive. Being with him at these times could evoke extremely powerful feelings, such as a fear that one was really harming him. These experiences felt close to a matter of life and death.

After many months of working with Nigel, the pattern of his panics seemed to be around mealtimes and food. He began to demand more and more food at the table, but never felt satisfied and would then panic. At bedtime, he would make endless demands but be unable to settle. He would often then start banging about in his room so that someone would be with him. Then when someone came, he would start whipping at the person with a belt or anything at hand. When it became necessary to stop him, he would panic and need to be physically held for half an hour or longer. Each time we thought we had understood something about Nigel we would try and anticipate his needs so that we could break this cycle. For example, by sitting with him at bedtime, or by helping him to see that there was always enough food for him. Occasionally it seemed that Nigel felt less anxious as a result of this anticipation. He began to look forward to some experiences and on occasion even seemed to feel satisfied.

However, he was just as likely to panic at the moment when you felt pleased about this! Working with Nigel could feel like 'madness' as there was so little that could be connected with

– connections that were suggested to Nigel were normally met with a hostile response that made it extremely difficult to continue any line of thinking. Needless to say, this onslaught could 'get under one's skin' and tap into any underlying fears that one might have about one's vulnerability, sanity or mortality! A defensive approach could develop as powerful feelings filled the environment around Nigel. Winnicott's (1963, p.93) theory about the breakdown that has happened but not been experienced seems particularly relevant to Nigel's case,

> In some cases emptiness needs to be experienced, and this emptiness belongs to the past, to the time before the degree of maturity had made it possible for the emptiness to be experienced.

As children like Nigel can seem so unfathomable and give you so little to go on, a supportive environment is crucial to sustaining the work that feels as if it is on the edge of a breakdown. Nigel's panics were a type of localised breakdown. The experience of these could evoke fear of a breakdown in the individuals working with him. This in turn could lead the whole team to question whether they could continue working with him or if they did, at what cost. These anxieties caused his social worker to fear that things were breaking down. It might even be considered necessary to remove Nigel to protect him from the developing breakdown. Winnicott describes the paradox involved in trying to make sense of the work involved with a child-like Nigel.

> In such a case any attempt on the part of the analyst to be sane or logical destroys the only route that the patient can forge back to the madness which needs to be recovered in experience because it cannot be recovered in memory. In this way the analyst has to be able to tolerate whole sessions or even periods of analysis in which logic is not applicable in any description of the transference. The patient then is under a compulsion, arising out of some *basic urge that patients have towards becoming normal,* to get to the madness; and this is slightly more powerful than the need to get away from it.
>
> It will be seen that if in such a case the breakdown is met by a psychiatric urge to cure then the whole point of the breakdown is lost because in breaking down the patient had a positive aim and the breakdown is not so much an illness as the first step towards health (Winnicott, 1965, p.126).

In the work above with Nigel, the more I tried to logically understand what was happening and to plan rationally, the more I seemed to feel defeated by his lack of positive response. All of my knowledge and previous experience seemed futile. Almost in desperation, I gave up trying to work out how he would get better and with considerable support decided to stick with whatever was going on for however long it would take. Paradoxically but not surprisingly according to Winnicott, Nigel did seem to make progress from this point – as if I had to experience the incomprehensible breakdown that had happened to him before he could also experience it in a real way and move on. Dockar-Drysdale (1990, p.121) in her short paper

'Panic', which Winnicott termed 'unthinkable anxiety', states, "I remember Winnicott saying that the most important factor in the treatment of panic is the acceptance of its reality."

Descent into hopelessness

Another way to look at some of these concepts is to consider what is happening from the perspective of hope. Hope can be seen as a positive life force and something that derives from the parent's handling and nurturing of the infant. The infant's distressing, uncomfortable and overwhelming feelings are safely contained by the parent. As a result, children with healthy attachments can withstand prolonged periods of negativity, because they have internalised good experiences giving them an internal reservoir to draw upon. They expect that things will turn out ok; they can wait for a 'better time' they hope will come. On the other hand, a child who does not receive this positive parenting may not develop a sense of hope. As Dunne (2007) has put it, "They may not be able to wait for a 'better time' because they do not know what a 'better time' is." A child who has experienced distress, followed by hopefulness, only to have those hopes obliterated can soon descend into a state of hopelessness where it is too risky to expect 'a better time'.

This is why Winnicott's (1956) concept of the antisocial tendency (including, greediness, stealing, lying, and generally making a mess) as a sign of hope is so important. The nuisance caused by the child also contains hope, which provides an opportunity for us to respond and nourish. Alternatively, reacting only to the symptom and missing the need will diminish the child's hope. It is possible that in working with a child such as Nigel, he raises our hopes and then violently dashes them to let us experience what has happened to him. We reach a state of hopelessness similar to what he may have felt. If we can experience this, survive it and somehow muster up a belief that things can get better, maybe the child can begin to feel a 'better time' is possible. Describing therapy work with sexually abused children, Trowell (1994) concludes, "The importance of sustaining hope in the child, the family and the therapist should not be underestimated."

Avoidance of breakdown

It is clear from the nature of breakdown, as described above, that there are many reasons why we and the child might want to avoid the feelings and difficulties connected with it. There is a mixture of pain and fear involved at the subjective level, feeding into tangible and objective anxieties, such as the safety of the child, those working with him and our accountability. The treatment involved is so demanding that Winnicott (1963, p.92) suggests that treatment can come to an abrupt end as a way of "playing the *patient's* game of postponing the main issue" or waiting for a 'trick of fate', such as death or running out of money! However, as Winnicott (ibid) argues, "….but alas, there is no end unless the bottom of the trough has been reached, unless *the thing feared has been experienced."* If we are unable to face and work with the real difficulties and pain involved we are likely to avoid a treatment approach.

Summary

When there is a breakdown involved in a child's formative years, we can expect there to be a significant impact on the child's development. The nature of the breakdown and the feelings

involved will be central to the child's ongoing situation and treatment. Depending upon whether the child was originally able to experience the breakdown or not, there are different implications for treatment. The genuine difficulty, risk and pain experienced by all involved create a strong potential for avoidance of the main issue and failure in treatment. As Maher (2003, p.280) states, "Treatment is risky, difficult and painful for everyone involved – and often too risky, painful and difficult to attempt."

Naturally, we need to ensure that risks are kept to an acceptable level, but what we deem to be acceptable will be strongly linked to our capacity to survive and manage the anxieties and fears involved. Therefore, an understanding of the value of the ideas such as those described in this paper is helpful. We need to expect the work involved with these seriously traumatised children to be challenging, messy and not to go as smoothly as we would like. When we are fully involved with the treatment process there will be times when we feel it is all going wrong. From this starting point, we then need to build our therapeutic capacity and support structures so that we can be resilient for the child, who unfortunately has been so damaged by his original and subsequent carers' inability to contain and respond to the primitive needs of a young infant. The risks involved in not treating the trauma are huge as the theme of breakdown is likely to recur throughout the child's future life with potentially devastating and costly consequences.

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DEVELOPING PEOPLE AND ORGANIZATIONS

Patrick Tomlinson Brief Bio: The primary goal of Patrick's work is developing people and organizations. Throughout his career, he has identified development to be the driving force related to positive outcomes - for service users, professionals, and organizations.

His experience spans from 1985 mainly in the field of trauma-informed services. He began as a therapeutic residential care worker in a therapeutic community for boys who had suffered trauma and other adversities. He has since worked with foster care services, residential schools, and intellectual disabilities for young people and adults.

Patrick has been a team leader, senior manager, Director, CEO, consultant, and mentor. He is the author/co-author/editor of numerous papers and books. Patrick is a qualified clinician, manager, and strategic leader. He has helped develop therapeutic models that have gained national and international recognition.

In 2008 he created Patrick Tomlinson Associates to provide services focused on development for people and organizations. The following services are provided,

- ✓ Therapeutic Model Development
- ✓ Developmental Mentoring, Consultancy, and Clinical Supervision
- ✓ Character Assessment and Selection Tool (CAST) for staff selection, and personal and professional development, in partnership with Dr Areti Smaragdi

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