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

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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

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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

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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

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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

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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,

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> 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

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– 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

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'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

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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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