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The Capacity to think: Why it is Important and what Makes it Difficult in Work with Traumatized Children.

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Abstract: The paper is about the kind of thinking required in work with traumatized children. It is not about following procedures and guidelines - it is more concerned with understanding the 'why' behind the behaviour before deciding 'what' we should do.

If those working with children can experience what seems incomprehensible, stick with it and make sense of it, it may be possible for children to feel we can help them do the same. All behaviour of children and staff is believed to have meaning. If we can find meaning, there is the opportunity of learning, growth and moving on.

Children placed in therapeutic communities will have suffered trauma. The same also applies to many youths and adults who reside in therapeutic communities. Therefore, this paper can be more widely applied to therapeutic community work and other settings where there is an intent to provide healing or recovery to emotional trauma.

The paper begins by looking at what trauma is and the impact it may have on child development. It considers the importance of thinking and why it so difficult in this work. The paper concludes by identifying the essential ingredients required if a thinking approach is to be sustained and effective.

Thinking and child development

In a recent article, the psychoanalyst and consultant child and adolescent psychotherapist at the Tavistock Clinic, Margot Waddell (2004, p.22) states the following,

> Psychoanalytically based psychotherapy has, for many years, presented an unwavering and increasingly evidence-based picture of the degree to which the developmental capacities and lasting inner resources of infants and young people are shaped, from the first, by the quality – that is the consistency and love – of the earliest relational environment. Initially that means the mother's or primary carer's mind. It is almost a truism that children learn to think by being thought about; that an infant's essential

> learning about him or herself takes place in the encounter of one mind with another from the very moment of birth.

This paper agrees with this statement and aims to look at why it is so important that thinking is central to our approach in work with traumatised children and how we might be effective in this difficult task. As child psychotherapist Paul Van Heeswyk (2004) has pointed out,

> It is not, as Franklin Giddins once observed, that two heads are better than one. Rather, it is that two (or more) heads are *needed* for one.

The thinking described in this paper is fundamentally and broadly a psychodynamic approach. As Schmidt Neven (1997, p.4) argues,

> The Psychodynamic approach puts forward the view that all behaviour has meaning, and that there is no such thing as communication and activity which has no specific communicable direction.

The need for thinking in work with traumatized children

Trauma can be understood to mean a profound emotional shock (Oxford Dictionary, 1992). Often, profound trauma in early childhood affects the whole of the child's development, causing serious delays and distortions. To recover normal development the trauma needs understanding. If a child is fortunate, this understanding can happen spontaneously at the time of the trauma. This may prevent long-term damage, making the trauma comprehensible to the child so that the experience can be endured, thought about and integrated. Without supportive emotional involvement, the trauma remains as an unthinkable experience that continues to haunt the child (Fraiberg, 1980). The child may experience this as an all-consuming nameless dread (Copley and Forryan, 1987, p.246), halting any further emotional development. Another possibility is that the child cuts off emotionally and seems emotionally frozen (Dockar-Drysdale, 1958) feeling nothing real. The highly anxious and emotionally frozen child are both lacking the ordinary capacity to form attachments, receive nourishment and engage in the ordinary experiences that enable growth and development.

Trauma is an experience that potentially can be recovered from and even made use of. The extent to which trauma can be thought about and integrated within the person's experience will depend upon several factors, such as, the emotional resources available to the person during the trauma and the nature of the trauma. The emotional resources include those of the individual experiencing the trauma and the support provided by others. The nature of the trauma includes the severity and frequency of the experience. A traumatized child needs to make sense of the trauma so that he can connect his feelings with his experience. Otherwise, the child's feelings become disassociated from his experiences in a way that can permeate his life.

The shock of trauma can cause regression in a child's development. A person who is in shock cannot think or attend to ordinary things. Regression can be a defensive falling back

to trigger a supportive and protective response from others. This aspect of trauma leads to the need for both understanding and nurture. The nurture is necessary to fill the gap created in development and to establish a sense of security that makes it feel safe to move forwards again.

To some extent, every child experiences traumas or shocks to their sense of being. Most of the time, these shocks are recognized by a carer and responded to, so the child quickly returns to a sense of continuity. Even if the shocks are unnoticed, they may not dominate the child's experience. The child learns that shocks are recoverable from and not overwhelming. The shock that can be thought about provides experience and knowledge of some of life's difficulties, enabling the child to anticipate difficulties and develop positive ways of managing them. It is hard to imagine how we would otherwise have any capacity to cope with the major shocks experienced throughout life. In this sense, child development includes the experience of trauma and recovery from trauma. Recovery from trauma is a healing process that can be called therapeutic.

There is not a simple solution to recovery from trauma. It cannot be prescribed but needs an environment where it is safe to think about the trauma, experience feelings about it and make reliable provision to heal it. This type of environment has been referred to as a 'holding environment' (Ward, 1998, Miller, 1993). Healing deep-rooted trauma is a demanding task. Severely traumatized children often become extremely antisocial, highly defended and developmentally delayed. They may be compulsively preoccupied in doing everything possible to keep the trauma out of consciousness. They could be constantly preoccupied with trauma but find no relief or resolution. They might have no conscious ability to think about the trauma, but continually re-enact it in an attempt to somehow make sense of it or evoke an understanding response from others. They may be desperately trying to forget the trauma and take flight from their feelings. Attempts to make steps forwards and towards others will constantly be disrupted by fears and anxieties.

Children who have suffered trauma in the earliest years and who have endured many further years of being misunderstood and let down, will not readily allow themselves help - allowing trust to develop is very threatening. These children are likely to attack the efforts of those trying to help them and if thinking about the children is part of the help, we can expect the thinking to be rejected and attacked (Copley and Forryan, 1987, p.258). Creating an environment where it is possible to think about children and their experiences is critical to recovery. There is not often a right or wrong approach in this work any more than there is to difficulties arising in childhood. There are signposts and reference points, but each child and each situation are unique. Children need care from people who have emotional strength and experience to draw upon, enough useful signposts and reference points, but also the capacity to think about each situation and child as unique. Therefore, developing a way of thinking about children is most important.

Writing about his experience as a leader of a therapeutic community for children and referring to a talk given by Dockar-Drysdale, Rollinson (2003, p.218) describes the importance of thinking and being able to tolerate uncertainty.

> She spoke to them about the dangers of becoming complacent or certain. She declared that the work must always proceed in a way that can tolerate doubt or not knowing. Only in this way can we hope to ensure that we are carrying on thinking. It is in absolutist or crisis cultures that there is no doubt; there is only absolute certainty. A culture with structures, boundaries and spaces will support thought. Thought will contain uncertainty and, thus, thoughtful responses can be made to the children, not only when adults are supporting healthy functioning but even when they are managing breakdown. The emotional 'mess' can be tolerated, and dealing with it can remain at the core of our work. It need not be driven out. Of course the sufferings of uncertainty are real, but nothing like the eventual suffering born of absolute certainty.

He goes on to state the 'true nature of our work' with traumatized children,

> Our focus should be less upon getting answers for someone and more about identifying (and helping the person to identify) the value that lies deep within each child, a child who almost always feels entirely worthless and unwantable on joining us (p.219).

Providing emotional containment and some of the difficulties

Many solutions to children's difficulties come from the kind of thoughtful attunement provided by carers that is both conscious and unconscious. The psychoanalyst Wilfred Bion (1962) described this quality of thinking as 'maternal reverie' and from this; he developed the concept of emotional containment. This is an activity shared by two individuals and is a predominant aspect of the mother-infant relationship. The infant's fears and anxieties are projected into the 'maternal container'. The mother is able to hold onto these feelings, think about them consciously and unconsciously and then return the feelings to the infant, but in a tolerable form. The infant also takes in and internalizes his mother's emotional availability and capacity to bear and think about his anxieties. Gradually through this experience, the infant develops his capacity for emotional containment. However, this process is not entirely straightforward. For instance, it is recognized that as the infant develops, he may become envious of the mother's capacity for creativity, which includes thinking. This can result in envious attacks towards the mother by the infant, which can cause difficulties in her thinking. The realization that the mother has thoughts, which the infant is not in control of, is also the cause of anxiety for the infant, related to separation and fear of not being in control. If the mother can contain these anxieties, they can be a spur to the development of the infant's healthy curiosity and individuation.

The kind of emotional attention that traumatized children need could be regarded as a professional state of mind, like Winnicott's (1956) description of a mother's primary maternal preoccupation with her infant. Although a child may need 'preoccupation', his sense of vulnerability and dependence will also be heightened, which can be frightening to him. The child who is not used to people thinking about him in a concerned way may find this extremely anxiety-provoking or may associate it with negative experiences where adults have only thought about him in terms of their own needs, however inappropriate. Our preoccupation or thinking may be constantly attacked, or perceived as something else by the child, such as intrusion or abuse.

Providing emotional containment can be particularly difficult during times of change when there is often an atmosphere of uncertainty and heightened levels of anxiety. The staff's and children's anxiety can feed into each other creating a spiral effect. When we are struggling to provide safety and containment for children, we often have less time and emotional capacity to think about our work, with forums such as supervision, team meetings, consultancy and training being disrupted. Paradoxically when thinking and support are most necessary there may be less time for them. On the one hand, there is a need to respond to the immediate situation, but also a need to hold boundaries and not become driven to anxious reactions.

While attempting to ensure that things are safe, our anxiety may convey the message that things are not safe, leading to further concern about safety and so on. If the nature of the situation is overwhelming, feelings of self-doubt may emerge in the staff team, along with a sense of hopelessness. Anything that does not bring immediate relief to these feelings and the problems involved can seem futile. For example, rather than think about what a child's acting out may mean, we may only see the level of seriousness or danger, and what we need to do to manage the situation. If this approach becomes a pattern, then it is likely that we miss communication at earlier stages and a child's acting out may escalate until he feels he is getting through to us in some way. For instance, Dockar-Drysdale (1990a, p.127) claimed that violent acting out is linked to a breakdown in communication.

> One could start by saying that the management of violence is its prevention. By this statement, I mean that, since all acting out is a breakdown in communication, it is our responsibility to keep in communication with the children in our care.

There could also be a growing sense of guilt felt by the adults because they have been unable to stop the behaviour. Thinking and talking in supervision or consultancy might even feel like an escape from responsibility. There is a danger in difficult periods that management and therapy become polarized and perceived as an either-or option. As well as management predominating and possibly eroding a therapeutic culture, focusing on therapy matters can be used as a flight from anxieties inherent in facing reality and the need for clear management. Menzies Lyth (1979) points out how there is a specific danger in the caring organizations, that systems, and particularly the managerial structure, become excessively infiltrated by attitudes and behaviour derived from professional attitudes to therapy.

At times, effective management can also be the most therapeutic intervention. For example, physically managing a situation appropriately may be experienced by a child as feeling understood, feeling safe, having destructive feelings contained and being looked after. This has similarities, to the way; Winnicott (1960) describes the mother's physical handling of her baby – it is based on an understanding of the child's needs that is fundamental to his experience and development.

As Peter Marris (1974) has stated in the title of his book 'Loss and Change', the two are inextricably linked together. Working with change is also about working with loss – all

change involves loss. Providing emotional containment following loss is difficult in the same ways described above. However, if we can maintain the capacity to think about loss, as with change there is the opportunity for growth and development. In his account of child development, Bion (1962), emphasized how the infant's experience of the absent mother or breast, can be a point of growth in the child's development - by helping him to manage separation and deal with feelings of loss. Bion argued that the infant's first thoughts would happen in response to the gap created by absence, i.e. by thinking about the mother who is not there.

The traumatized children we work with will have suffered many losses. I use the word suffered rather than experienced, as in many cases they will have not had the necessary support to make sense of their losses and to integrate the experience. Eva Holmes (1983), sums this up with a comment made to her by a child, which became the title of a paper about children and loss - 'I'm Bad, No Good, Can't Think'. She talks of the child's struggle to come to terms with pain and loss, and says,

> Central to this struggle seems to be the transformation of pain from something which has the character of an overwhelming physical attack into something which can be carried in the mind as experience (p.75).

During a child's time with us in a residential setting, there will be further losses. However, we have the opportunity to help the child experience these further losses in a meaningful way, and potentially at the same time to work through unresolved matters related to earlier losses. Because of our awareness of a child's history, we may become worried and feel guilty about any further losses imposed upon the child by ourselves. For example, by our decision to leave for another job. Similar feelings of guilt can apply to other instances of our absence, such as when we have a vacation, time away for training and illness. Unfortunately, if we do not understand and process our feelings of guilt, negativity is likely to dominate absence and loss, in a way that swamps all opportunity for therapeutic gain.

Thinking about antisocial behaviour

Antisocial behaviour is prevalent in traumatized children and our understanding and response to this is crucial in meeting the child's needs. Winnicott (1956a, p.309) made the connection that antisocial behaviour, sometimes described as delinquent behaviour could be hopeful,

> The antisocial tendency implies hope. Lack of hope is the basic feature of the deprived child who, of course, is not all the time being antisocial. In the period of hope, the child manifests an antisocial tendency.
>
> The understanding that the antisocial tendency is an expression of hope is vital in the treatment of children who show the antisocial tendency. Over and over again one sees the moment wasted, or withered, because of mismanagement or intolerance. This is another way of saying that the treatment of the antisocial tendency is not psychoanalysis but management, a going to meet and match the moment of hope.

At times when children are acting in an antisocial and destructive manner, there can be a strong feeling within adults that this behaviour is a sign they are doing a bad job and things are going wrong. There might be a wish to eliminate the behaviour or acting out. Winnicott's paper looks at the hopeful aspect of delinquency or antisocial behaviour. If we take a less reactive response to the behaviour, we may be able to see the communication and need beneath the behaviour.

The children we work with will also attack our attempts to think about and understand them. This is linked to their overwhelming sense of mistrust. While children are likely to notice and attack any retaliatory and punitive feeling in an adult's response, they are also likely to attack a benign response. Children may react in a paranoid way to benign interpretations that adults make as if they are being persecuted. Feelings such as persecution, hopelessness and despair may be projected or displaced onto the adults. There could be a tendency for the adults to take flight from these feelings rather than recognize and continue working with them. Children may be testing to see whether adults when faced with difficult and challenging behaviour can survive and continue to meet needs. Dockar-Drysdale (1990b, p.146) states the importance of communication in this work,

> So I would be quite sure that direct and open communication is essential in every residential place, so that at no time will children or their caring people be dominated by collusive anxiety.

The above insights epitomize the essential nature of thinking. Without thinking, the typical response to antisocial, challenging, or problematic behaviour might be reactive or based defensively upon following procedures. Winnicott showed us how to view antisocial behaviour as the child's attempt to express a need and an opportunity for us to respond by meeting the need. Being open to this possibility can make all the difference to our response, which may in turn make the world of difference to the child. If we do not understand the communication in the child's behaviour, his despair and sense of hopelessness are likely to become increasingly entrenched.

Noticing Winnicott's point that the treatment of the antisocial tendency is not psychoanalysis but management, it is worth briefly expanding upon the implications for work with traumatized children and particularly in residential and institutional settings.

As Menzies Lyth (1979, 1985) has stated it is possible to have management without therapy, but not therapy without management. Management includes safety, boundaries and all aspects of the organizational structure. Without these conditions, traumatized children will not be able to make use of therapeutic work. Feelings of insecurity, anxiety and mistrust are likely to be overwhelming. In residential and institutional settings, the management structure of the whole organization is relevant to the therapeutic task. All aspects of this structure will have an impact on the therapeutic task and potentially be internalized by the children. For example, a management structure that allows for little autonomy and responsibility in the staff is not likely to encourage the growth of autonomy and responsibility in the children.

Examples of difficulties in thinking in work with traumatized children

As an illustration of difficulties in thinking, I will give two short case examples – one involving work with an individual child and the other more on an organizational level. In both examples, the staff involved are working in organizations where the concept of thinking about children is an explicit part of the culture.

Example 1

I had taken up a new post, which included the responsibility of overseeing the work of a team, working with traumatized children in a residential setting. Attending a team meeting, I was quickly presented with a sense of bewilderment within the team and one staff member asked if I could get a psychiatrist to see one of the children, Katy. The acute sense of difficulty was centred on severe states of panic that Katy exhibited every bedtime. Every evening as bedtime neared Katy would become increasingly anxious, building up into a panic state, where she would frantically run about, throwing things, shouting and screaming. This would always end up with staff physically managing her to ensure she and the other children were safe. This could go on for hours before she would eventually settle, not so much with the relief of having worked something through, but with pure exhaustion. Whatever the staff tried would not seem to make much difference and they, became exhausted, feeling useless, hopeless and dreading the next bedtime. Probably, partly as an attempted solution and partly as an expression of anger, the team had begun to offer rewards to Katy if she could 'manage' her behaviour at bedtime and sanctions if she misbehaved. It is not unusual that children who feel worthless and unlovable may evoke a harsh response towards them, to confirm their view. In this situation, restrictive and impersonal responses are more likely than creative, thoughtful ones.

It was clear to me that Katy was in a state of abject terror, completely overwhelmed and unable to 'manage' herself. Rather than punish her, the team needed to find some understanding and empathy towards her. First, I considered how awful this experience felt for the team. Once the team felt understood we were able to explore Katy's history and put her behaviour into context, where, whilst it was extreme it was also comprehensible as an expression of her anxiety and an attempt to manage it in some way. The team were then able to work out together exactly why betimes might be so difficult and plan a way of working with Katy from that. For example, the team considered whether the panic was like infantile separation anxiety manifesting itself at bedtime or whether she may have experienced abusive experiences at bedtime or both. The team found ways of working with Katy that helped her gradually to feel more secure, less out of control and over time, actually to enjoy a nurturing bedtime routine with clear boundaries.

It seems a reasonable hypothesis, that the staff's bewilderment, the dread of bedtimes, and the sense of being out of control, reflected Katy's feelings. As I was able to think about the team's experience, they were able to think about Katy and most importantly to sustain their thinking through the difficulties. The team were capable of thinking the right sort of things but had temporarily lost their ability to do so. I was able to help restore their thinking, partly by being removed from their direct work with Katy and the turmoil involved. My involvement with the team was intense for a few weeks, until their work with Katy settled

and then over time, a few years, there was little left to remind us of this very challenging period.

Example 2

A well-established service providing treatment for traumatized children in a residential setting entered a period of major change. Several senior staff, with many years' experience in that setting, were leaving, partly for personal reasons and because of re-organization. My role was to provide practice support, in a clinical supervisory role, to the service provided by the establishment. This service had a group of 60 staff and problems began to emerge, throughout the whole organization. Symptomatic difficulties such as high turnover, illness and general malaise escalated.

My experience of spending time there, in what had become a fire-fighting capacity was one of turmoil, chaos, huge anxiety and not surprisingly a great difficulty in thinking. Staff, in all kinds of meeting or discussion I encountered, expressed excruciating levels of anxiety and distress. This felt like an onslaught and it was difficult to maintain sympathy let alone empathy for the staff. The first task was to achieve nothing more than to 'be' and to survive.

If my experience was anything to go by, it is perhaps not surprising that virtually all meetings that potentially could have provided a thinking space were cancelled or disrupted. There was no sense of a containing or holding structure. When this dynamic takes hold, there is often a rational reason put forward to justify why circumstances have made it necessary to cancel this and change that. There is always some truth in this point of view – does the turmoil cause the loss of thinking space or the loss of thinking space cause the turmoil? Do we manage the turmoil to restore our capacity to think or restore our thinking to manage the turmoil? Working with turmoil without thinking is only sustainable in the short term before our responses become increasingly reactive and fuel the fire rather than put it out.

In situations like this, any leader or manager who tries to provide a forum where communication can take place is offering the possibility of a way forward, but also the anxiety of facing the reality of the distress that is being experienced. It is clear that if we are unable to work with the reality in our situation, we have little hope in helping the children face, stick with and move on from their realities. The alternatives of flight, escape, manic activity, withdrawal might not seem such a bad option, even if they are a great cost to individual development and collective progress. Whoever says, let's do what is necessary, face reality, stick with it, is likely to be perceived as a threat bringing potential pain and danger into sharp focus. This can feel tantamount to abuse. Traumatized children will often be quite direct about this and call such a person an abuser, paedophile, amongst other insults and attacks. Staff might find themselves becoming increasingly unsure of themselves and their task.

As professional staff, we tend to be less direct in our testing and need for containment, though our underlying communication can have a similar quality. On the one hand, we can have a group of people involved in escape, excitement and withdrawal and on the other, someone or a few, talking and thinking about things that to the others seem completely

irrelevant, boring or at worst abusive. Those that are in flight from reality are likely to experience some guilt about this, even if it is only at an unconscious level. The guilt in itself is a threat, as an acknowledgement of it brings the person experiencing it closer to the reality she is avoiding. Therefore, it is likely that the guilt is projected onto those who are challenging the flight by holding onto reality. These people are then subject to both undermining attacks and projections of guilt, which can increase their self-doubt and depressive feelings. The differences between all involved can become polarized and immensely difficult, to the point of feeling completely hopeless and irretrievable. Faith, conviction and resilience are required. On the hopeful side, there will probably be a collective wish that the necessary solution is provided because it is the only real hope. This need will in turn require that whoever is to provide the necessary solution will be tested to the limit to ensure, they are safe, trustable and reliable.

When we are working with children traumatized by abuse and in particular sexual abuse, being clear about things is often responded to as if it is abusive. The dynamics of seductive excitement and the defensive denial of it can be re-enacted. Whoever disturbs or challenges the status quo may receive the full torrent of emotion described above, as if that person is the abuser. It is often the 'whistleblower' in an abusive regime, who is made to feel as if she has performed an abusive act – or to carry feelings of self-doubt and depression. Similarly, boundaries and roles in abusive scenarios are muddled and blurred - who is the adult and who the child? Therefore, in our work situation an adult who is clear about her boundaries and stays appropriately in her role, is facing the abused child with the reality, that what happened was inappropriate, adults are adults and children are children and there is a difference. There is likely to be huge pressure to muddle this reality and blur boundaries. This will come from the children, ourselves, the organization, children's social workers, parents and others, as the reality of abuse is painful, often with major ramifications for many people and however hard we work at it, ambivalence will exist. This pressure will continually push itself into the organization so that at all levels, there will be a tendency for things to become unclear and muddled. Frustrating though this may be, the seductive trade-off is that it can feel more comfortable than facing reality and working with it. Conversely, if we can think about reality and the meaning of behaviour, it is less likely that we will act out in a way that perpetuates the difficulty of the child, ourselves and organization. For this to happen, the holding environment must be suitably equipped.

Essential ingredients to support thinking

I have outlined some of the necessary ingredients in the paper and now I will summarize them. Without these ingredients, it will not be possible to sustain a thinking approach and ambivalence towards thinking will soon pre-dominate. These points will only be made briefly and serve as pointers to areas that need further elaboration.

- The organization providing the service must fully understand and be committed to the concepts described in this paper. This must be at all levels of the organization and in particular the senior roles. The culture must be an open one, where within appropriate boundaries communication and thinking is encouraged rather than censured or dismissed.

- There must be sufficient key staff who have internalized through experience and training the processes and difficulties involved in thinking. They will need to have internalized their experience and training to the point of clear conceptualization. Staff will also need to be suitably resilient. Staff recruitment methods such as those described by Khaleelee (1994), and Khaleelee and Tomlinson (1997) can be very helpful in assessing the emotional resilience of staff and suitability for the task.

- As discussed, work with traumatized children can evoke strong and primitive feelings. If we are to think about these feelings and understand them, there will need to be specifically designed forums for this purpose. The forums, which can include staff supervision, team meetings, consultancy and training, will need to be clear in terms of boundaries and task. The forums will need to be reliable and consistent. In work with children who present such challenges to our thinking and ability to hold boundaries, and where staff have to deal with high levels of uncertainty, it is helpful that the key structures for staff support provide an element of certainty. If staff know when and where certain things happen, this leaves the space to work out what is happening and to focus on the children's needs. Miller (1993, p.4) describes how the 'holding environment' (taken from Winnicott's idea of what the mother provides for her infant) of an organisation can promote psychological security for its staff if it is effectively managed. He states that there is,

> ……the need for a match between the holding environment that staff have to provide for their clients for patients and the holding environment that organisations and management provide for them.

If we develop the approach and environment described in this paper, it is possible to provide for these children within a residential setting, the psychological succour and emotional holding needed, so that their trauma can heal. Indeed, the therapeutic residential setting may be the most robust, containing and suitable environment for this purpose.

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