PATRICK TOMLINSON BLOG

THERAPEUTIC APPROACHES IN WORK WITH TRAUMATIZED CHILDREN

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About This Blog

I am writing the blog, because I enjoy writing and I like the idea of creating something, which lasts and can be used in a positive way.

This blog is primarily for individuals and organizations who provide services for children and young people who have been traumatized – particularly by abuse and neglect, but also from other circumstances. So on the one hand it may be of interest to a counselor, therapist, foster or residential care worker, but also to those who manage and lead organizations. It may also be of some interest to people who are more generally involved with trauma work, and also child development and parenting. The blog is aimed to be widely relevant rather than related to specific local issues.

Sometimes I wonder about the two different roles of care/therapy and management. In my career I have done both, carer/therapist and also manager/leader. It is tempting to focus on just one, but I think this is an unhelpful approach. There is often a split in our work between care and management, as if the two are in conflict. In some societies this problem is described from a business perspective, i.e. carers and other practitioners, don’t care about business and vice-versa. Politicians are often concerned with the cost of providing care and therapeutic services, and therapeutic service providers bemoan the politicians’ apparent lack of concern about people’s needs.

There is now undisputed evidence, which shows that attention to the needs of children and young people, and their families, especially those who have been disadvantaged, makes great social, political and economic sense. This means that people on both the side of care/therapy and also management/business need to collaborate. This can cause discomfort, because people don’t always like to see the two sides of the fence, so the easy option is to keep the two separated and split.

On this blog I will discuss both. Sometimes this causes me to feel uncomfortable. If I see myself at the organizational leadership level, how will people in those roles think of me discussing issues such as: children who need to play; how to communicate with children; meeting the regressed needs of a traumatized child? How will carers and therapists feel about me talking of management, leadership and outcomes?

I think my own discomfort is a reflection of the split – so I run the risk of falling out with those on both sides of the fence. And this is exactly what happens when organizations begin to reflect the traumatizing environments, the young people they work with have come from. I think the two sides need to be successfully integrated – in recent years this has been called the struggle for congruence in service of the children’s best interests (Anglin, 2004). You can’t have therapeutic work, which is incongruent with management and leadership practices, and vice-versa. The organizational consultant, Menzies Lyth (1979) said that it is possible to have management without therapy, but not therapy without management.
I have experienced leaders and senior executives who understand the importance of the fine detail involved in the therapeutic work, because they have been there themselves. A highly skilled leader can run an effective organization, without necessarily having a background in that organization’s work. However, I think in such complex work I think there is something to be said for a leader having experience at every level of the work he/she is in charge of.

The style of the blog, will have a focus on integration, which I have just realized, is very relevant to the first 14 years of my career at the Cotswold Community – where the task of the work was to help ‘Unintegrated’ children, to become ‘Integrated’ (Winnicott, Dockar-Drysdale). The term Integration is now also used in neuroscience by people such as, Daniel Segal. In this blog I will try to integrate various themes: from many different professional disciplines, such as the psychodynamic approach and neuroscience; the micro and macro levels; the past and the present; and from different cultures.

I will write at least weekly, and sometimes more. I want to be practical and will offer links to relevant resources wherever I can. I would like interaction, and to create a sense of a community, so please: make comments; be constructively critical; ask questions; share anything useful; and also suggest topics for further discussion. Please also use my email to make suggestions and to talk with me directly. ptomassociates@gmail.com

Reference


Since writing the above over a year ago and reflecting back, a few things stand out. First of all, my aim to write weekly turned out to be over-ambitious! It has been more like 3-4 weekly. I prefer to write something more significant and it takes more thinking over. I also like to add in links, useful references and resources. The theme of integration has been consistent and I have enjoyed developing thoughts about this. The content in this document, includes some of the thoughtful and kind comments made by readers. I have included those that add something additional to the subject. I also found on occasions that after I had written a blog, further thoughts developed so in some case I added them afterwards. I think this shows how writing can be helpful in terms of development – once we get some thoughts out, there is space for new ones to evolve.
The Value of Reading and Writing in Work with Traumatized Children - Part 1

As this is my first blog it seems fitting to write something about the value of reading and writing in our work with traumatized children. I will also say a little to introduce myself. With all of my blogs, I will just aim to share something that is hopefully useful and thought provoking – I see writing and reading as a way of stimulating a process rather than providing an answer with a full stop/period.

Back in 1985, having finished my degree and a year out, most of which was spent on a Kibbutz in Israel – I needed to get a job and I had decided to work with children who had difficult childhoods. The first job I applied for, through a small newspaper advert was at the Cotswold Community, a therapeutic community in the Cotswolds, England, for ‘emotionally disturbed’ boys. Like a small village on a farm with 4 houses for the boys, 10 in each – and the majority of staff having their own houses on the 350 acre site. The Community had been set up by the Government as an experiment and alternative to the ‘Approved Schools’, which basically were a disaster leading to 85% of residents eventually ending up in prison. The therapeutic approach of the Community was a success, reversing that figure, and became established as an internationally renowned ‘centre of excellence’.

I didn’t understand much of this when I started. Previously I had done a few evenings at a youth club and a module on social psychology on my Social Administration degree. However, it was deemed through the selection process, which included a 3 day visit, that I had a suitable personality for the work.

The boys had suffered extreme levels of abuse and neglect, often beginning from birth. What I saw in my first few weeks was shocking to me. I had no idea that young children could be so developmentally delayed, with such extreme behavior purely as a result of their adverse experiences.

As soon as we began work, each new staff member joined a weekly training group (around 8 of us in a group). We would be given a paper to read in advance and then in a 1 hour meeting, discuss its relevance to our work. We were thrown in at the deep end in many ways – but we had a lot of support around us. We were given papers by well-known people in the field such as Donald Winnicott, Bruno Bettelheim, Isabel Menzies-Lyth, Fritz Redl and David Wineman, and Barbara Dockar-Drysdale. Some of the reading was difficult to understand at the time - and some was so helpful to me in explaining what I was experiencing.

The expectation on us to read, relate what we read to our own work experience and also develop our own thoughts was very significant. The work with the boys was often bewildering, confusing and completely impossible to understand – as well as being very challenging to the point of overwhelming and soul destroying. I now understand this as a reflection of the children’s own experience of the world they grew (or didn't grow) up in. Without the reading, the guidance of the senior people in the organization and the space to think about the work together – there would have been little possibility of making sense of anything.
Our consultant, Barbara Dockar-Drysdale would often begin a meeting by asking what we had been reading. She would be most concerned if she discovered people weren’t reading very much and this was not something you wanted to disappoint her on!

In recent years, I have read some of Dr. Neil Thompson’s work and I like what he has to say about the importance of theory. There can be a tendency in work with children to say ‘it’s common sense’. Neil argues strongly against this notion. Common sense suggests there is a normative way of thinking – it is often a cultural perspective and exclusive to those who belong to that culture and way of thinking. The idea of common sense doesn’t encourage critical thinking – if it’s common sense what is the need to analyze, think or debate? So reading can give us a perspective that might be outside of our own experience. This is especially important in work with traumatized children – partly because few of us may have actually experienced what they have. The solutions to what is not a common experience are also often not ‘common’ sense.

The kind of therapeutic approaches that are most helpful in our work are often counter-intuitive. For example, these are a few ideas that I have found very helpful; delinquency can be a sign of hope (Winnicott); getting better can make things worse; depression can be a good thing – as one young boy said to me, ‘I don’t need cheering up, I need cheering down’. Reading helped me learn and understand these concepts.

My next blog will continue on this theme. The person who started me off in my career was John Whitwell the Principal at the Cotswold Community back in 1985 – I had the fortune to work with him for the next 14 years. For a little more reading, this is his excellent website, which has many papers and resources by people that were involved with the Cotswold Community.

www.johnwhitwell.co.uk
The Value of Reading and Writing in Work with Traumatized Children - Part 2

I said in my previous blog, that in my first job at the Cotswold Community we were expected to read about our work with traumatized children.

Thinking about this I have realized that our culture also had a big emphasis on reading to the boys. Every night (more or less) we ended the day, with a small supper and everyone would sit in a circle while one of the adults would read a story for 10-15 minutes. As well as the story being enjoyed, the consistency of this routine was also very important. We know that repetition and a reliable routine is one of the most important elements in the work with traumatized children – making the world around them an intelligible, predictable and safe place, and helping with emotional regulation. This can be especially important at the end of day, which is often the most stressful time for traumatized children.

After the story the boys would go to bed, and some of them would ask their carer to read to them while they settled down. Another part of our culture was to provide individual reading times during the education day. Some of the boys had very little vocabulary, couldn’t read very well and may not have experienced being read to before. Research has since shown how important having a rich vocabulary is for a child’s development. Being able to form a narrative is also very important for traumatized children. The story of their trauma is unfinished - it had a beginning that just keeps going relentlessly on, whereas a story has a beginning, middle and end.

It is interesting to think that many of the stories told to infants, by their most trusted carers are often frightening - involving witches, monsters, and grandmothers disguised as wolves to devour the unsuspecting child! There is something satisfying about being told such stories, surviving and being able to move on from it. Children who are traumatized are stuck and not able to move on from their all too real stories of terror.

A story told becomes something between two people, that both can have a role in managing and relating to. Many ‘fairy stories’ are symbolic of primal fears and desires. In a sense the story can be a safe way of the parent bringing a primal issue to the surface and helping manage the feelings associated with it. So the parent or carer, becomes an ally of the child in dealing with these issues, as well as the focus of them!
Of course not all childhood stories are frightening, but there is a reason why stories such as, Hansel and Gretel, Snow White, Little Red Riding Hood are so enduring and intuitively read by parents to their young children. Probably the fact that the story is usually read from a book is of some relief to the child, who might fear that such ideas could come straight out of the parent’s head!

Writing about the educational aspect of learning and stories, Shonkoff and Phillips (2000, p.156) capture the essence of the pleasure that can be involved in being read a story,

“Accordingly, the literature on early learning environments is not about accelerating learning with expensive toys and explicit early instruction. Instead, it focuses on how adults interact with young children and set up relatively ordinary environments to support and foster early learning. While this sounds like a subtle distinction, it captures the difference between a child who is taught to recite the alphabet and a child who is read to every night and becomes interested in letters and words because they are associated with the joy of being in her father’s lap, seeing beautiful pictures, and hearing a wonderful story.”

At the Cotswold Community, as well as being expected to read – we were also expected to write. Our yearly calendar was divided into terms or what we called sessions, each one being 6-8 weeks long. After each session, all staff members were expected to write an ‘end of session report’. The remit was fairly broad – anything relevant to our recent work experience that we wanted to share. It could be short or long – normally between a paragraph and a page. Sometimes people would write about their work with a particular child; or a group of children; their experience in a team; an organizational issue; a concept or idea they were thinking about. Once all the reports were written (usually about 30 of them) they would be typed and distributed for all the staff to read. We would then discuss them in various meetings throughout the Community, picking up on themes and pertinent issues.

This process required a high level of commitment and discipline. I have never come across anything like it since. At the Community it was done without fail for over 15 years. The process of writing required us to be reflective – to think over a period of time and consider what stood out? What questions did we have? What were we learning? What did we feel worth sharing? It also enabled us to realize that by writing about our own experience, we could make a difference and have an influence in the organization. It was a feedback loop from the individual into the system as a whole. Feedback loops like this are vital for the health of a system – they provide essential knowledge of what is going on. We could also write things that might cause a negative
reaction – there are always challenges involved in writing and expressing ourselves. Encouraging open communication is central to the task of enabling traumatized children to recover, so it is essential to establish this in the culture.

Early in my career, I learnt that in our work we are also researchers. Though we learn from people who went before us, we were also encouraged to add something to an existing idea or concept, through our own experience. Tom Farrelly (2013) states the two-way process of this,

“However, as well as being consumers of research, practitioners can and should strive to be producers of research.”

Numerous people working at the Community wrote papers or in a few cases, books. This was a little intimidating but also inspiring. The ‘model’ for our work was closely linked to the Psychoanalyst and Pediatrician Donald Winnicott, who also happened to be a prolific writer.

Writing has continued to be a theme in my work. A few examples – when I studied for an MA in Therapeutic Child Care in the 1990’s we were required to keep a reflective journal – simply writing a diary of one’s work, what stood out, what sense we made of it. Writing can be an excellent way of reflecting, which is so important in social work/therapy. It can also be helpful to one’s development in general.

As Friedrich Nietzsche said, writing can also be a good way of just getting rid of thoughts! He actually said that he had found ‘no other way of getting rid of his thoughts’ (Gane and Chan, 1997, p.39).

If we write we might also find we have a dialogue with ourselves – we may see something we hadn’t noticed before and our ideas can change shape as we write.

After the Cotswold Community I moved on to work at SACCS in the UK, who also work with traumatized children and young people. One of the unique approaches used at SACCS was its Life Story Work. This enabled children to tell their own stories and also work through the feelings and issues involved. They would do this in words, pictures, drawings and symbols that would be made into a life story book.

This process was hugely valuable to many children. For adults as well as children, writing can be a form of working through trauma – putting the story down can bring a sense of closure. Having a coherent narrative is something that a traumatized person often doesn’t have, so developing
one that can be integrated as part of one’s identity is a goal of recovery. Bessel van der Kolk and Alexander McFarlane (2007, p.17) state,

“Treatment needs to address the twin issues of helping patients (1) regain a sense of safety in their bodies and (2) complete the unfinished past. It is likely, though not proven, that attention to these two elements of treatment will alleviate most traumatic stress sequelae.”

Completing the ‘unfinished past’ can be considered as completing the unfinished story, the story of trauma that has a beginning but not an end. On a similar theme, our child psychotherapist consultant Barbara Dockar-Drysdale, used to suggest that if we thought of a nightmare as an unfinished dream, it might help us think with a child about it might be completed. Often this was a helpful perspective.

I also work with the Lighthouse Foundation in Melbourne, Australia – who provide a Therapeutic Family Model of Care for homeless young people. Lighthouse has a strong belief in the value of storytelling - it is built into the culture of the organization. It could be said that our stories define who we are and it is the sharing of them that creates our individual and shared identities. Stories are often told without writing. The verbal tradition of storytelling is powerful and well established – but putting something into the written word, is an essential part of our culture and work.

While writing this blog I was jogged into looking up my old ‘end-of-session reports’ and found that I still have them. Here is my first brief report.

December 85
I joined ‘Springfield’ (one of the homes) for the last five weeks of the session. The session seemed to be quite a steady one though the Christmas week was very busy. I think that I have settled in well and am getting used to the demands of the work. However, I definitely wouldn’t describe my experience as a ‘Honeymoon’. I have come in for quite a lot of testing out, especially from two of the boys. Quite often I have felt that I should have known more about what is going on and what to do in certain situations. I have realized how important communication within the team is and reading, in helping to overcome this. The weekly training group has also been useful.

My next end-of-session report described how I got my nose broken - it was a steep learning curve!

References


Press at: http://goo.gl/6N4jWW  When it comes to reading, this document is not for the faint hearted! Over 600 pages of research on the science of child development, produced for the USA Government. It does have some excellent information in it.


Comments

Liza Aitken, Management Consultant, England

I really enjoyed this Patrick. I love stories and believe they teach us as adults as much as they teach as children. All of us can make sense of the world through stories.

Patrick Tomlinson

This is a good blog by Lisa Cherry on writing, she also writes on Trauma

What Do We Really Gain From Our Writing?  http://goo.gl/NnJsz5

Catherine Knibbs, Cyber Trauma & Abuse Researcher, Supervisor and Child Trauma Therapist, England

I use stories as they are cohesive for the narrative and experiential parts of the brain, which in traumatised children is often un-integrated. Using this method builds top down/bottom up and left/right integration. Nice blog, thanks for sharing!

Patrick Tomlinson

Thanks Catherine - Interesting what you say - as the children I refer to at the Cotswold Community - were assessed as emotionally unintegrated (Winnicott's concept of unintegration) and our task was to enable them to achieve emotional integration. More recently Dan Siegel (2006) has said,

“The central idea of interpersonal neurobiology is that integration is at the heart of well-being.” (Siegel, 2006).

This has just been recommended to me by someone who read the blog. Frank Cottrell-Boyce: Open the Box of Delights - a video of his talk at this year’s CELSIS conference in Scotland, on the importance of reading to children and storytelling, http://goo.gl/AeXeXE

"When a child is read to, they experience alertness and attention without anxiety. Reading aloud offers children and young people the experience of sharing with peers and carers and joining with the long traditions from which our cultures are built."
One of the points Frank Cottrell-Boyce makes in the video below is that being read to does something special and important to a developing child's brain. It is so powerful, such that Frank says reading to children, purely for pleasure should be a part of daily life. Just as we did at the Cotswold Community with our bedtime stories and individual reading times. We believed in the value of these experiences, which was focused more on pleasure rather than education.

Frankie says that reading stories should be provided unconditionally, without expectation of a response at the time. He says that stories are stored in the mind and may be used or come back to a person, when they need them in the future. He points that out that we get through life by routine and predictability, and stories provide a safe way of experiencing unpredictability - also of imagining ourselves outside of where we are. Frank's views affirm, what I have mentioned about the importance of the daily routine. We also used to provide individual children, reading times during their education day - where they would simply be read to for 15-20 minutes or so.

Reference
Siegel, D.J. (2006) Series Editor’s Foreword, in, Ogden, P., Minton, K. and Pain, C. *Trauma and the Body*, New York: Norton

Postscript
Since writing those blogs I came across this interesting article, *Science Shows Something Interesting about People who Love to write*, [http://goo.gl/y8tgjU](http://goo.gl/y8tgjU)

The article refers to research suggesting that writing may have physical as well as mental health benefits. Some of the claims initially sound a little farfetched. However, there is a logic to the idea – reflection, which can be achieved through writing, helps to create a perspective, which can reduce stress, which is likely to impact positively on physical health. Interesting to think how the professional requirement to write, which I refer to in these blogs may have been a more significant antidote than we realized.

And just recently I found that Bessel van der Kolk (2014) has reported the same thing in his book, *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma*. He refers to an experiment carried out by James Pennebaker at the University of Texas in 1986.

“He began by asking each student to identify a deeply personal experience that they'd found very stressful or traumatic. He then divided the class into three groups: One would write about what was currently going on in their lives; the second would write about the details of the traumatic or stressful event; and the third would recount the facts of the experience, their feelings and emotions about it, and what impact they thought this event had had on their lives. All of the students wrote continuously for fifteen minutes on four consecutive days while sitting alone in a small cubicle in the psychology building..................The team then compared the number of visits to the student health center participants had made during the month prior to the study to the number in the month following it. The group that had written about both the facts and the emotions related to their trauma clearly benefited the most: They had a 50 percent drop in
doctor visits compared with the other two groups. Writing about their deepest thoughts and feelings about traumas had improved their mood and resulted in a more optimistic attitude and better physical health.” (p.239-240)

and,

“Writing experiments from around the world, with grade school students, nursing home residents, medical students, maximum security prisoners, arthritis sufferers, new mothers, and rape victims, consistently show that writing about upsetting events improves physical and mental health.” (p.240-241)

Reference

Empathy Part 1

Is the Capacity for Empathy the Key Quality in our Work with Traumatized Children?

One of the first things I learnt in work with traumatized children, is that the Capacity to Empathize marks a critical stage in a child’s development. The children and young people, who were placed with us often had no capacity for empathy or very little. However, this didn’t mean they didn’t have the potential to develop it. The development of empathy was one of the key aims of our therapeutic work, as it is for many of us that work with and look after children.

We carried out a needs assessment on each child to determine his stage of development, how it had been disrupted by trauma, and how his developmental needs could be met. Dockar-Drysdale’s (1970) Need Assessment, described empathy “as being the capacity to imagine what it must feel like to be in someone else’s shoes, while remaining in one’s own.”

The consequence of not being able to recognize another person, as a separate being with their own emotions, thoughts and needs causes havoc in daily living. It can also be dangerous as the child has no conscious sense of the hurt they are potentially able to cause, and therefore also, little if any remorse.

More recently, Cameron and Maginn (2008) claimed,

“Increasingly, too, it is the development of empathy which is now being viewed as the antidote to both childhood and adult violence—an argument which is well evidenced in the ‘Worldwide Alternatives to Violence’ report (2005). Children who do not experience attunement with a caregiver may fail to develop empathy altogether. Secure attachment is therefore fundamental to children’s socialisation and wellbeing.”

To develop empathy a child needs to experience empathy. That sounds straightforward on paper, but can be extremely difficult to achieve, when working with children and young people who have long passed the age at which empathy would normally develop. For example, it is not easy to ‘empathize’ with a 10 year old’s ruthless lack of concern towards others, especially when this has to be lived with 24 hours a day. On top of this, a traumatized child often actively rejects any attempts to show empathy towards him/her. This is partly because empathy might connect him with his traumatic experiences, which he is desperate to keep out of mind. It might also cause him to feel vulnerable as empathy normally connects people, and children who are mistrustful are resistant to being connected.

As well as showing empathy, another key factor in helping a child develop empathy is creating a safe, reliable and nurturing relationship where the child may begin to feel attached. Attachment usually leads a young child to develop the capacity for feeling concern towards the attachment figure. This makes sense from an evolutionary survival point of view - the vulnerable dependent infant, benefits from being able to understand the protective carer. If the infant is completely dependent on the carer it is necessary for her to develop a level of understanding that helps reciprocate and grow the attachment relationship, which is critical for survival.
Young infants can be seen to make efforts of contributing something positive towards their attachment figure. For this to work well the infant needs to understand something about how the other feels. Normally by the end of the first year an infant has some ability for understanding what thoughts and feelings are in another’s mind. When empathy begins to develop it may be rudimentary but it is very important. It may be a gesture like an infant, wanting to feed the parent a spoon of her food. Though she hasn’t quite worked out that the parent might not like baby food, she is moving in the direction of wanting to give something good to the other. By 18 months an infant might be able to show sympathy to another infant who is distressed. A securely attached infant, who has had more attuned experiences with his caregivers, is more likely than an insecurely attached infant to show empathy.

Graham Music, in his excellent book ‘Nurturing Natures: Attachment and Children's Emotional, Sociocultural and Brain Development’ states, “Children who suffer neglect and receive little attuned attention can be less able to make sense of another’s mental states. Others who experience more abusive rather than neglectful parenting can develop a skewed understanding of others.”

Empathy is different to sympathy, which can be shown without necessarily understanding much about how the other feels. It is also different to projection, where one’s own feelings are projected onto the other. Various clinicians have emphasized how empathic understanding is therapeutically helpful in the process of therapy. According to Nelson et al. (2014, p.140),

“Research has shown that therapists trained in mindfulness have better patient outcomes, and even a patient’s visit to a physician for a common cold can be made more effective when the clinician is open and empathic.”

Shame is often a theme involved with trauma, and especially that caused by abuse. Dr. Brené Brown talks about Empathy and Shame being on a spectrum with both being at the opposite ends. https://goo.gl/DTVyKw

If children need to experience being empathically understood to develop empathy, those working with and caring for them will also benefit from receiving empathic support. This can help make what feels intolerable, tolerable. The capacity to feel empathy towards another isn’t static, it changes according to circumstances. For example, if someone is feeling anxious, it isn’t so easy to feel empathy.

If care workers are expected to show qualities such as, empathy, reliability and dependability in their work then these qualities also need to be reflected in all aspects of the organisation’s culture and the way it operates. The same could be said of the support provided by the extended family and community, in the case of parenting.

Not long into my own career and after a period or relentless testing out by the young people I worked with, I felt exhausted and demoralized. There were many times when I felt like I’d had enough. One day I was telling our consultant Barbara Dockar-Drysdale how I felt. She told me
that sometimes the most important thing you can do, is just survive and be there the next morning. This seemed manageable to me and by saying this she was empathizing with exactly how difficult it was for me. I found this very helpful and I did survive!

I try to share a few useful links in my blogs

This book by Maia Szalavitz and Bruce Perry is a fascinating and very accessible read on the subject of empathy – exploring it from many different perspectives.

A couple of good blogs on empathy from the Daily Good,

“If you think you’re hearing the word “empathy” everywhere, you’re right. It’s now on the lips of scientists and business leaders, education experts and political activists. But there is a vital question that few people ask: How can I expand my own empathic potential? Empathy is not just a way to extend the boundaries of your moral universe. According to new research, it’s a habit we can cultivate to improve the quality of our own lives.” - Six Habits of Highly Empathic People, Roman Krznaric, http://goo.gl/wZh35s


References


Comment

Joanne Prendergast - Social Care Worker at St Bernard Group Homes, Ireland

Such a great article Patrick. When infants are "held" by their mother’s arms and psyche for the really important first year and beyond, they develop the neurological functioning that is biologically mapped out. Deficits in this magical process, impact on young person’s view of the world and capacity to interact with others, amongst many other aspects of their well-being. Empathy is such an important aspect to this and this article has summarised the importance of this. In addition if the organisational culture is non-congruent to the overall task of the therapeutic work, the environment can become chaotic for all, and this in turn can be detrimental rather than healing.

Gulchekhra Nigmatjanova - Advocacy Advisor at SOS Children’s Villages, Uzbekistan

Many thanks for sharing this enhancing article indeed. All true to me and I think empathy is key quality of a social worker, actually it is a quality which makes us human of high conscious. Bravo!

Janet Eades - Teacher at Capitol area community action agency, USA

Just survive and be there the next morning. Sounds like our organization every start of a new school term. Never know where you are going to be placed or what your hours may be. Whew, I will remember that comment.

Marlaine Cover - Transforming the Life Skills educational process for the benefit of humanity present and future, USA

Empathy is teachable and core to humans' mandatory curriculum of communing with others. Imagine how every avenue of human interaction will improve when we embrace proactive education for emotional literacy as passionately as we do for academics, sports and music. Much appreciate your advocacy Patrick!

Patrick Tomlinson

Thanks Marlaine - I tend to think of empathy as something that can be facilitated and develops through experience.

Lynda Noble - Senior Recovery Practitioner FDA at SACCS, England

I remember feeling worthless, angry, emotional and then finally understanding that they were not my feelings at all, but the feelings of my key child. It takes time and understanding to be able to recognize this and lots of good supervision, which is extremely important in child care organisations.
Empathy Part 2

'Ghosts in the Nursery' – A Powerful Example of Empathy in the work with a Mother and Baby

Since writing my last blog on empathy I found a book, which included a paper that had a big impact on my learning in the 1990’s. I had lost the book, and after a while it turned up on Amazon ‘used and new’. The paper was by Selma Fraiberg et al., ‘Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships’.

The paper is about work with mothers and their babies (sometimes fathers too). The babies were in major peril, bordering on the need for removal for their safety. The main thrust of the paper is that unresolved issues from the mothers conflicted pasts were preventing them from parenting their own babies. The way forward was to work with the mother’s unconscious pain, through empathic understanding – to enable her to be in touch with her own feelings. This would then reduce the risk of the mother’s history being re-enacted with her infant. It is a great example of why early intervention is so important. Here are a few excerpts that beautifully illustrate the quality of work, with my own comments in-between,

“In every nursery there are ghosts. They are the visitors from the unremembered past of the parents, the uninvited guests at the christening. Under all favorable circumstances the unfriendly and unbidden spirits are banished from the nursery and return to their subterranean dwelling place. The baby makes his own imperative claim upon parental love and, in strict analogy with the fairy tales, the bonds of love protect the child and his parents against the intruders, the malevolent ghosts.”

Interestingly the use of fairy tales as a way of dealing with potential threats to the parent-child relationship is mentioned. Angus Burnett commented on a previous blog, where I also referred to fairy tales - that sometimes it takes a long time for something that is read to permeate and be understood. I think he is right!

“The methods of treatment which we developed brought together psychoanalysis, developmental psychology, and social work in ways that will be illustrated. The rewards for the babies, for the families, and for us have been very large.”

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I think the integration of different disciplines can be very helpful. The paper goes onto discuss one of their cases. At the initial assessment meeting with a four month old baby (Mary) and her mother (Mrs. March), Mary became very distressed,

"What do you do to comfort Mary when she cries like this?" Mrs. March murmurs something inaudible. Mrs. Adelson (psychologist) and Mrs. Atreya (assessor) are struggling with their own feelings. They are restraining their own wishes to pick up the baby and hold her, to murmur comforting things to her. If they should yield to their own wish, they would do the one thing they feel must not be done. For Mrs. March would then see that another woman could comfort the baby, and she would be confirmed in her own conviction that she was a bad mother.”

The intuitive thing for the ‘professionals’ might have been to pick up the baby, but as they point out interventions like that can be counter-productive. I think this can be what happens, when we think that parents need training. The training might help, but it is less likely to, if there isn’t an understanding of why parenting is difficult for the parent. However, if there aren’t major underlying issues an educational focus may be effective.

“The Mother’s Story (Mrs. March)
It was a story of bleak rural poverty, sinister family secrets, psychosis, crime, a tradition of promiscuity in the women, of filth and disorder in the home, and of police and protective agencies in the background making futile uplifting gestures. Mrs. March was the cast-out child of a cast-out family.”

“This led us to our first clinical hypothesis: "When this mother’s own cries are heard, she will hear her child’s cries."

I find that hypothesis poignant – rather than show or teach the mother how to parent, the emphasis was on showing her empathy. The first few weeks of work, were focused on the aim of hearing Mrs. March’s unresolved distress.

“But now, as Mrs. March began to take the permission to remember her feelings, to cry, and to feel the comfort and sympathy of Mrs. Adelson, we saw her make approaches to her baby in the midst of her own outpourings. She would pick up Mary and hold her, at first distant and self-absorbed, but holding her. And then, one day, still within the first month of treatment, Mrs. March in the midst of an outpouring of grief, picked up Mary, held her very close, and crooned to her in a heart-broken voice. And then it happened again, and several times in the next sessions. An outpouring of old griefs and a gathering of the baby into her arms. The ghosts in the baby’s nursery were beginning to leave.”

That sounds like an amazing moment, when an intervention that has been so challenging, begins to show a sign of working.

“Within four months Mary became a healthy, more responsive, often joyful baby. At our 10-month testing, objective assessment showed her to be age-appropriate in her focused attachment to her
mother, in her preferential smiling and vocalization to mother and father, in her seeking of her mother for comfort and safety. She was at age level on the Bayley mental scale. She was still slow in motor performance, but within the normal range. Mrs. March had become a responsive and a proud mother.”

When having to emotionally contain so much anxiety, there can be little more rewarding than seeing these kind of outcomes. And being able to intervene so early, is valuable beyond words.

“For us the story must end here. The family has moved on. Mr. March begins a new career with very good prospects in a new community that provides comfortable housing and a warm welcome. The external circumstances look promising. More important, the family has grown closer; abandonment is not a central concern. One of the most hopeful signs was Mrs. March’s steady ability to handle the stress of the uncertainty that preceded the job choice. And, as termination approached, she could openly acknowledge her sadness. Looking ahead, she expressed her wish for Mary: “I hope that she’ll grow up to be happier than me. I hope that she will have a better marriage and children who she’ll love.” For herself, she asked that we remember her as "someone who had changed."

The paper, which also includes other case studies, concludes with this sentence,

“In each case, when our therapy has brought the parent to remember and re-experience his childhood anxiety and suffering, the ghosts depart, and the afflicted parents become the protectors of their children against the repetition of their own conflicted past.”

Also using the metaphor of ghosts, Bessel van der Kolk et al. (2007) emphasize the importance of integrating a personal narrative of the trauma,

“Many traumatized people continue to be haunted by "them" (unintegrated traumatic memories), without an "I" to put these feelings and perceptions in perspective. Treatment at this stage consists of translating the nonverbal dissociated realm of traumatic memory into secondary mental processes in which words can provide meaning and form, thereby facilitating the transformation of traumatic memory into narrative memory. In other words, what is currently implicit memory needs to be made explicit, autobiographical memory.”

In many ways the same principle applies in work with traumatized children. They need to integrate their experiences, including the feelings involved, as part of their history. As well as enabling the child to move on from the past and live positively in the present, it also greatly improves the possibility that the cycle of trauma will be not passed on to future generations.

Having read ‘Ghosts from the Nursery’ again after so long, I am reassured to discover that it is just as impactful as it was the first time. It is a very moving and excellent example of the use of empathy. As well as finding the book, I have also discovered that the paper can be downloaded here, http://goo.gl/64qwRG
Sadly Selma Fraiberg died just a year after this book was published. A few comments about her by Constance Brown, [http://goo.gl/GJ3M3g](http://goo.gl/GJ3M3g)

Selma Fraiberg was a psychoanalyst, author, and pioneer in the field of infant psychiatry. A woman and a social worker in a profession dominated by male physicians, Fraiberg rose to prominence because of her brilliance, originality, and dedication. She devoted her life to understanding the developmental needs of infants, to creating programs that promote infant mental health, and to reaching parents and policymakers through clear, persuasive prose. Fraiberg accomplished enough in her life to fill three careers. During this last phase of her career, Fraiberg started the Child Development Project at the University of Michigan, which served troubled families, trained clinicians, and developed a treatment model that has been widely replicated. Selma was feisty, shy, and intellectual. She was known to colleagues and students as brilliant, demanding, fiercely principled, difficult, and inspiring. Those close to her knew that she was shy and self-conscious, and that public exposure caused her strain. In 1981, she received the Dolley Madison Award in recognition of her critical role in the field of infant mental health.

Reference


Janette Schulte • 2 years ago

Dear Descendants of Selma Fraiberg,

I want to let you know what a critical impact Selma Freiberg's book The Magic Years made for me as a mother, as a student of Early Child Development, and as a human being. I had a very difficult childhood with very little genuine love and desperately wanted to create my own family. I intentionally studied all I could at UC Berkeley on Child Development and Education because I discovered I adored working with children but did not dare have my own precious children unless I understood thoroughly the needs of children, the critical early stages especially. Her work, The Magic Years distilled all I learned about in my undergraduate years in a very touching way, showing me that given a little understanding and love and guidance, children will develop just fine and in fact will develop to be kind, loving beings on their own. I saved my copy all these years and am just so sorry I never wrote her myself to tell her the impact she made, not just on giving me the courage to be a mother, way different from my own mother, but in understanding that I was just as precious as all those children quoted in example after example in her wonderful book.

We all have our Magic Years, no matter what stage we are in. Your mother's book gave me self-love and self-acceptance of a kind and loving person dedicated to children despite all odds. So thank you, Selma Fraiberg, and thank you to her descendants. Please, please, make her book available again today. And a word of advice; if you can find anyone to write an adaption in simpler, more practical terms as a manual for the everyday parent, it would go a long, long way in teaching today's young parent about everyday kindness, acceptance, and understanding in raising their children they themselves chose to bring into this world. Really, it would make an incredible difference. I just know that as wonderful as The Magic Years is, many young parents just need a distilled version in some form. Please consider this for today's world to become a little kinder.

Thank you so much. Would you do me the kindness of responding to my comments with an email letting me know you have sent this on to the appropriate person? Thank you so much!

Sincerely,

Janette Schulte
Empathy Part 3
The Wounded Healer

The concept of the Wounded Healer, was first explained to me by Olya Khaleelee. Olya is a corporate psychologist and organizational consultant, and I had the privilege of working with her on assessing people’s suitability for working with traumatized children. The links between a person’s history and personality, and how this might interact with the work was the key part of the assessment. Her reference to the wounded healer was an acknowledgement that emotional wounds might be a part of what enables a person to become a healer. Our assessments enabled us to make a judgement as to whether this was likely to be the case or not.

I had a striking experience a few years ago that captures the essence of the link between an adult’s childhood and the work with traumatized children. I was providing training for a group of care workers who were about to start work with traumatized children in a residential setting. The aim of the training was: to encourage psychodynamic thinking - to think about the meaning beneath a child’s behavior and from that insight to consider appropriate responses.

I presented the following scenario to the group. One of the children, Luke, had disappeared from his home and a care worker was looking for him. After a while the carer saw him from a distance by a pond. It looked like there was a cat in the pond, attached to a long piece of string that Luke was holding.

The group was asked what they thought was going on and what the carer should do immediately and in the longer term? They did some work in small groups and then gave feedback. The general consensus was that the first thing that should be done was to make the situation safe, ensuring Luke was safe and the cat was rescued.

Possible reasons given by the group for Luke’s behavior were along the lines of,

- maybe Luke was angry and was taking it out on the cat
- he might be treating the cat in a cruel and abusive way that was a re-enactment of how he had been treated. Traumatized children tend to re-enact their own experiences of being powerless, towards others who are less powerful than themselves.

In terms of what to do, the responses were,

- explore Luke’s thoughts on what he might be doing
- make it clear to him that his behavior was inappropriate and help him to understand why
- help him to put his feelings into words
- use the situation as an opportunity to talk with Luke about his abuse in an empathic way

These were all thoughtful and plausible suggestions. As the discussion went on, one of the carers Tim, who had been looking increasingly thoughtful, hesitantly suggested that Luke might have been trying to save the cat. The group reacted by laughing a little.
I was surprised by Tim’s comment as I had taken the scenario from a child’s case history and that was exactly what he was trying to do! The child had had a traumatic and tragic experience when he was younger. He was out playing unsupervised with his younger brother who fell into a pond and drowned. The child felt responsible for his brother’s death and was blamed by his parents.

From then on the child had a history of re-enacting this trauma in different ways as a desperate attempt to resolve it. He put the cat in the pond so he could save it, which he hadn’t been able to do for his brother. I explained this to the group who were clearly surprised by my explanation and how Tim had made such an unexpected and insightful comment.

When the group took a break, I approached Tim who had seemed very preoccupied and asked if he was ok. He said that he made the comment, because when he was a child he had been with his younger brother who fell into a canal and drowned. I empathized with the distress this training scenario may have caused Tim, but also commented on how his own experience had given him the capacity for empathic insight.

Tim then said that he had been physically abused by his mother as a child, and asked me if I thought he would be able to do the work given his own experiences. I suggested that it is very difficult to predict how our own experiences will either help or hinder us in the work.

If we have integrated our experiences into our life history, difficult experiences can help us provide empathy and understanding. On the other hand, the work may raise very painful feelings, some of which we may have repressed or not integrated and things can feel overwhelming. Research has shown that it is not the facts of our history that are necessarily the problem, but whether we have been able to integrate these facts into a coherent narrative of who we are (van der Kolk et al., 2007).

I explained to Tim that the important thing would be to talk about his feelings about the work in supervision and other relevant forums, especially if something was troubling him. Tim actually turned out to be an excellent carer, showing great levels of patience and understanding with the children he worked with over many years.

The key points of learning from this were that

- A person’s own traumatic experiences can be useful in developing empathy and insight, if those experiences have been integrated into their own history and identity.
- Luke had not been able, so far, to integrate the trauma of his brother’s death and was compelled to re-enact it.
- Whenever we are working with trauma, talking or thinking about it, our own experiences will be brought closer to the surface. As with this example, what we might learn is unpredictable.
I had not anticipated such an emotive exercise and was moved by the poignancy of it, which had an emotional impact on me. Working with trauma evokes powerful emotions and often when we least expect it. Tim showed how something constructive can come out of such awful experiences. How the capacity for healing can develop out of our own emotional wounds.

This has been adapted from, Barton, S., Gonzalez, R. and Tomlinson, P. (2011) *Therapeutic Residential Care for Children and Young People: An Attachment and Trauma-informed Model for Practice*, London and Philadelphia: Jessica Kingsley Publishers, Also translated into Japanese.

Reference

Models in Therapeutic Work with Traumatized Children - Part 1

The term model has arisen significantly during the last decade or so, to imply a well thought through and coherent way of providing a service. Other terms that may mean something similar are framework, ethos, philosophy and approach. I will describe how I see some of the important principles of a Model.

One of the first uses of the word model in our field of work may have been by John Bowlby (1969) who used the term ‘Internal Working Model’. This related to the model internalized by an infant as to how the world around him works and his place in it. The model is based on the infant’s perception of his experience. For example, I am lovable/unlovable, carers are protective/harmful and the world is safe/dangerous. It can be seen from this that the model includes the infant’s view of himself, those closest to him and the wider environment or world. The model is an internal template that the infant may not be conscious of and though it is resistant to change, it can be modified by new experiences.

As with parenting the outcomes of a service for traumatized children are going to be determined by: the quality of relationship between the child and those closest to him (parent/carer/therapist); the immediate context and quality of relationship (extended family/organization – culture, leaders, managers and supervisors); the local community; and the wider socio-political-economic environment.

While trauma may mainly be perceived as an issue between the ‘victim’ and ‘perpetrator’ it is not helpful to ignore the context or ecological aspect. Trauma happens within an environment, such as a home, a family, a neighborhood, a community and a society. A model for recovery needs to consider not only the different levels of the context but also the relationship between them. For instance, it probably would not be helpful to create a model, however rational it might seem in clinical approach, if it conflicts with cultural values and norms. Supporters of the ‘ecological model’ rightfully argue that outcomes can be improved by intervening at any level of the context. For example, ‘the best way to improve outcomes for young children is to improve the support provided to primary caregivers’, or ‘a reduction in poverty might reduce instances of trauma’.

If we are going to influence and change a child’s ‘model’ it makes sense that the approach, must also involve, working directly with the child’s internal and external worlds. This will include all of those who work with and look after him as well as the context within which everything happens. Most importantly these different elements must be integrated. As James Anglin (2002), the Canadian researcher on residential care has said, they must be ‘Congruent in the Best Interests of the Child’.

While most people might not think consciously in terms of models, in essence it is as Bowlby described, the way we make sense of the world around us and our part in it. For example - what do I want to achieve; what are my ideas of the methods I might use to achieve it; what evidence
do I have about the effectiveness of the methods; and what are the likely outcomes; including unintended outcomes or side-effects?

When we are a team providing a service, it is especially important that we have a shared model that we work to. Without this the service is likely to be fragmented, inconsistent and potentially conflict ridden. Clearly, in work with traumatized children this is not helpful. Rather than provide children with the high levels of consistency and predictability that is necessary for their recovery, the service is more likely to resemble the environments in which they were traumatized.

When I began my career in 1985 at an English therapeutic community (Cotswold Community), the organization had a very well developed model. It wasn’t referred to as a model, but a therapeutic approach. The most striking feature for me was that the organizational aspects were fully incorporated into the model. Leadership, role clarity, authority, management, structure and boundary management were seen to be equally important to the ‘treatment task’ as the direct clinical work with the children. Not only were both aspects important in their own right, the relationship between the two was understood to be critical. This can be thought of as the relationship between therapy and management. It can also be reflected in what people sometimes refer to as the relationship between ‘business and care’.

A comparison can be made with the task of parenting. Parents with an infant strike a balance between attending to the management of the environment and focusing on the infant’s emotional/physical state. Keenan (2006, p.33) referred to Winnicott’s conceptualization of these two functions that are both necessary to ‘hold’ the child,

“The object-mother is the mother as the object of her infants desires, the one who can satisfy the baby’s needs ... The environment mother is the mother in the role of ‘the person who wards off the unpredictable and who actively provides care in handling and in general management’ (Jacobs, 1995, p.49).”

Sometimes the parent may become so caught up with the infant on an emotional level that other issues are neglected, like shopping, housework, paying bills, etc. At other times the parent may be so busy with these things that the infant’s emotional cues aren't noticed. Holding the two together is a challenge that ebbs and flows. Unless things become extreme in one way or another, the overall experience for the infant will be ‘good enough’.
From this example, it can be seen how all these aspects of the infant’s environment are connected to his overall sense of well-being. It would be no use to have emotional needs met within the context of an environment that is not being well managed. The consequences of the lack of management may lead to a deterioration that would cause stress for the parents and potential hazards in the environment, which would impact negatively on the infant. The same applies in organizations. It could be argued that effective management provides the container in which therapy can take place. It is crucial in the residential treatment of traumatized children that the whole organization and every activity within it are aligned to this work. Confirming the importance of this, Canham (1998, p.69) argued, “...the whole way the organization functions is the basis for the possibility of an introjective identification.” The children will internalize not only the relationships they are most directly involved with but also the way the organization as a whole functions. (The above section has been adapted from Barton et al., 2011)

The balance between the different needs described above and how the potential conflict is managed is a key part of the therapeutic task. Individual needs always have to be responded to within a context. For example, how are individual needs met within the context of group needs? We do not help children and young people by ignoring the reality of the context, which includes the resources available. We have to find creative ways of meeting needs. For example, a parent with 5 children is going to manage things differently compared to a parent with 1 child. The outcomes for each child are determined by how the situation is managed – by the parents, the extended family and the child’s own resourcefulness. In some cultures the local community has a big role in looking after all the children. Isaac Prilleltensky (2006) argues that wellness occurs in the inter-relationship between the personal, the relational and the collective.

When I began my career we had a team of 5 care workers looking after a group of 10 children. Nowadays, with the same type of child it is more likely to be a team of 10 looking after a group of 3. The challenging question in the face of such change is whether the core principles of a model can be sustained?
Models must be alive and adaptive – they must be open systems and have feedback loops, so they can receive the information they need from all parts of the system. In other words a model can never become a fixed entity, as one part of the system changes other parts must adapt. It must continuously evolve. For example, a change in the external environment, politically, economically, or professionally will require an adaptation. As with evolution those that survive are the most adaptive.

My next blog will focus on the specific benefits of having a model.

References


Comments

Joanne Prendergast - Social Care Worker at St Bernard Group Homes, Ireland
Very informative critique on the aspects of well-intended child care models. The flexibility around areas that create the holding environment are crucial to this very delicate but valuable task.

Andrew Collie - Organisational Consultant, England

Thanks for this Patrick. Child care without a model is child care without concern for the child.
Models in Therapeutic Work with Traumatized Children - Part 2

In my previous blog, I discussed how models develop in childhood as internal ‘templates’. By the time a child becomes an adult, he or she will have a way of relating to others based on their ‘internal working model’. Once a child is born the parents ideally have some clear ideas about what will be good for their baby, and they also have the capacity to provide it.

We all know from observing and/or being a parent that there are different versions of how to look after children. Usually, our version is based on our own childhoods, what we have learnt in our families. Most parents want to parent like theirs did, if they have internalized a positive experience of being parented. If they have not and they haven’t been able to acknowledge the difficulties, they may also parent in a similar way and repeat the negative experiences. This is how a cycle of deprivation and abuse continues. Or if they are more in touch with the reality of their own childhood difficulties, they may wish to be different than their parents and bring up their children in a better way. However, even with all the knowledge now available, few first time parents will have received much formal education on parenting.

Add into the equation that both parents will have had different childhood experiences and will have differences and similarities in their views on parenting. Some difference may be positive because it provides their children with a wider range of qualities. However, too much difference on dealing with basic issues could be too contradictory, unpredictable and unhelpful. Sometimes the parents might not be conscious of their differences until: they have a baby; their child reaches certain ages; or particular situations arise. Each stage and event of childhood can have the powerful effect of resurfacing strong feelings in the parents, related to their own childhoods, which they may not have been aware of, or had repressed. On the positive side, how the parents manage their feelings, work together and resolve differences are vital parts of parenting. It provides children a role model on how we can positively cope with difficulties and how difference can be useful rather than negative.

The relevance of parenting, is clear when we think of therapeutic models. Whether we are working in foster care, residential care, therapy or teaching, parent-child dynamics will be involved. The task will require that the foster carer, residential carer, therapist or teacher can reflect upon and untangle what is in the child’s best interests. One child who was living in a residential children’s home complained to me,

‘You can tell how all of the carers were brought up, because they all have different rules and attitudes at mealtimes.’

There is nothing like the way we eat together to highlight differences! In the absence of a clear and agreed model the carers were doing their own thing based on their personal points of view. There could be 8-10 adults in a team, so the potential for confusion is huge. It can be hard for two parents to provide the necessary consistency for a child, so providing it among a large team is challenging.
When there is a team working with a child it is especially helpful to have a model. Traumatized children need predictability and consistency, to help them feel safe and to stabilize their emotions. Only once this achieved can they begin to make use of the experiences they need to recover and develop. Without a clear model, chaos is likely to rein. For many years various reports, investigation’s etc. into ‘looking after children in care’, have found that a clear ethos or philosophy, along with strong leadership are the most consistent factors in positively run organisations that have good outcomes for children and young people. What used to be termed a philosophy of care, is now more frequently referred to as a model of care. Whether we are talking about care, therapy or teaching, having an appropriate model is essential.

A model needs to be based on the best information available for the specific task. For example, if we are teaching an autistic child, the research and theoretical base will be different to that for therapy with a traumatized child. There may be some overlaps but there will also be some differences. I had a steep learning curve, when I began work with traumatized children and another one when I moved and spent some time working with children who were diagnosed with Asperger’s Syndrome. The model that worked with one didn’t work with the other. It can be said that in working with any child, we need to be adaptive to each child’s personality. For instance, it is now well-known that everyone has different learning styles and therefore different learning needs. But the differences between children with different types of complex needs are especially challenging to adapt to. Bessel van der Kolk et al. (2007) has said that in work with complex trauma a variety of approaches are necessary and,

“Helping people who develop posttraumatic stress disorder (PTSD) in the aftermath of a traumatic experience is a complex process that cannot simply be described like a cookbook recipe.”

A model can provide guiding principles, standards, specific techniques, do’s and don’ts. But most importantly it should equip the people doing the work with the ability to think within a framework and work things out together. A model provides parameters within which things can be tried and monitored. What works can carry on and what doesn’t may need re-thinking or persevering with. Having a benchmark provides a point from which new ideas can be critiqued. If there isn’t a benchmark how do we notice how far something is drifting - a bit like walking in the fog, without even a vague marker to keep a sense of direction.

Having a good model on paper is not a guarantee of good outcomes. There are other important factors that will determine success. For example, is the model embedded in the culture, is it understood and do people feel a sense of ownership. It is particularly important that a model is culturally sensitive and takes into account cultural values, language and belief systems.
In work with traumatized children, as I mentioned in the previous blog, every aspect of the environment and how the different parts work together is vital. Different terms like, integration, congruence and joined-up have been used to explain the importance of this. A trauma informed environment is necessary and this includes everyone who is in any way involved – carers, therapists, teachers, managers, senior executives, administrators, etc. Creating this requires a cultural change because how people think about the children, the task and how they relate to each other is all relevant to the model.

Effective leadership and implementation of a model is a challenging task. To fully establish a strong culture with a clear model can take at least 2-3 years, if not longer. By this I don’t just mean that a model is created on paper, but that it becomes genuinely reflected in the way that individuals and the organisation as a whole works. When a model is fully established, it can be recognized by the positive qualities that run through the organisation, with everyone speaking the same language. It will be reflected in the consistent quality of relationships between adults and children and at all levels of the organization. Ultimately the aim of any model is to achieve the best possible outcomes for children, so continually evaluating, learning and adapting must be part of the culture. As I have said, a model is never finished, it is always evolving.

Reference

The Need for Integration – Part One
Leadership and Management

Before moving on to the subject of leadership and management I will give a little background context. Partly as I intend to write a series of blogs on the subject of integration.

At the beginning of my career the concept of ‘Integration’ was one of the first I learnt about. The particular use of the term was from Donald Winnicott, the child psychoanalyst and pediatrician who described integration as a central part of child development. According to Winnicott (1962) the infant is born ‘unintegrated’. Through the process of the infant’s fragmented experiences being held together by the ‘good enough’ parent, he achieves integration and a distinct sense of being a whole person. This normally happens by the end of the first year or so.

Since then I have found the concept of integration to be central in many ways - to work with traumatized children; to the way organizations are run; to the way different services, professionals and other stakeholders work together; and also to the way society functions. Winnicott wrote about integration over 50 years ago, and though Daniel Siegal (psychiatrist and pediatrician) uses the term from a neurobiological perspective and may not mean exactly the same thing, it is interesting that he says in 2006, “The central idea of interpersonal neurobiology is that integration is at the heart of well-being.”

During the years of my work with traumatized children I moved from practitioner roles to management and leadership roles. I have moved back and forth between the two. Sometimes I wonder which camp I am in, but am beginning to think I’m clearly in the one that is about joining the two together. Another lesson from many years ago was that management and therapy need to be integrated successfully. Good management is necessary for good therapy to take place and sometimes good management is therapeutic in itself. The same could be said about any kind of practice in the human services – it can only be truly effective in a well-managed context.

I am sure many of us are familiar with the dynamic of management and therapy being at odds with one another, the same with business and care, and also leadership and management. In one organization, the Executive Director felt frustrated with therapists who would often say that they needed ‘space’ rather than make time to listen to his visionary ideas. And I am sure the therapists felt frustrated that his grand ideas didn’t help much with the immediate realities of their work. Vision is crucial to create an inspiring and important mission, and so is doing the job at hand, however mundane or unpleasant it may seem. It is the integration of the two that is critical. I had a vision when I joined a therapeutic community for traumatized boys, of doing ‘therapeutic work’. I wondered during the first few weeks why most of my job evolved around cleaning toilets, being shouted and spat at, and looking for ‘missing’ boys in the surrounding countryside. It took a while to fully understand that this was part of the therapeutic work necessary for the vision to be achieved. Thankfully those in charge knew this only too well and also what was needed to support the task at hand. The vision was grounded in reality.
An important question is why ‘splits’ tend to occur. One answer put forward is based on the concept of social systems developing as a defence against anxiety (Menzies Lyth, 1959, 1961, 1970). To briefly explain - the nature of the work task is inherently anxiety provoking and involves emotional pain. The difficulty is defended against by creating a more simple and primitive solution. The reality of the task, is replaced with a more bearable but split solution such as, we would be able to do this if it wasn’t for ‘management’, etc.

For example, it is easy for leaders to have a grand vision and not have to worry about how it will be achieved. It is easy for managers to become focused on methods and practices regardless of whether they help meet the desired vision or not. The leader with a grand vision tends towards charismatic and the manager focused on methods tends towards bureaucratic. The charismatic leader blames the stifling, red tape, bureaucratic managers for failure and the managers blame the unrealistic and ‘out of touch’ leader.

It also makes everyone’s job seem easier as only one difficult thing needs to be mastered, rather than the more complex integration of two difficult things. Organizations may fluctuate between the search for a heroic leader or a new management system, as if either might provide a magical solution. This might provide short term relief but in the long term it is ultimately defeating and unsuccessful. The system as a whole is dysfunctional. What is needed for effective performance is not the splitting of management and leadership, but the integration of them, whether within the same person(s) or between people. The functions of leadership and management may be separated but they need to respect and understand their interdependence, and work together in an integrated way. The same can be said for management and therapy, and business and care.

Splits, which are based on unconscious reactions to deep anxieties and fears are especially likely in the human (or people) services due to the core nature of the task. For example, trying to provide a service to people in great need (sometimes literally a matter of life and death), when it never feels that enough can be done. In particular, this is compounded by harsh financial realities such as those in times of ‘austerity’. The sense of ‘impossibility’ and ‘hopelessness’ is difficult to bear for everyone involved. Leaders can defend themselves by becoming distant from the reality of the work. Those more directly involved can blame leaders for not caring enough about people and too much about business. And everyone is avoiding the deep changes that are required in the organization as a whole.

In recent decades, where every type of business and industry has had to deal with a rapidly changing and more complex world, the same kind of anxieties and fears are becoming common in most workplaces. How many people can say with confidence they expect their job to last for 3 years let alone for life? The life span of jobs at all levels has reduced massively and this is just one of the insecurities affecting the modern day workplace. Survival on an individual and organization level is precarious. Constant change in a complex and highly competitive market is the norm. Without good management, which is in effect good technology, people, methods, procedures and policies, an organization will fail to achieve its vision. Without a vision that is motivating, inspiring, creative and stretching – performance will fall short in today’s demanding environment.
To do something well, on its own is not ‘good enough’. There also has to be an outcome that can compete with what anyone else can do at the same cost or less.

What is needed is an improved capacity to face the very real difficulties involved in the task. This means being more in touch with complexity, fears, threats and anxieties. To achieve this, it is necessary to have a culture with structures and processes that enable these difficulties to be acknowledged and worked with. This requires capability and time, and the difficulty of putting it in place cannot be overestimated. Short term thinking will see this as an extra cost and use that as an excuse to avoid it. When time and effort is put aside, because the work will be difficult, with potential vulnerability and conflict for all involved, it might feel as if the process isn’t helping. There may be a tendency to give up rather than a determination to work through difficulties. This requires strong leadership and belief in the process. Those organizations that pay attention to the need for integration, which is far more difficult than getting one part rather than the whole to work well, are likely to become the most competent type of organization.

I will finish with a brief example that captures much of what I have said. A few years ago, I was studying on a course in Strategic Leadership for Social Care. As part of this, I had the fortune to visit Bromley-By-Bow in London, which had been heralded as an example of community regeneration based on social entrepreneurism. The picture is of the Bromley-By-Bow Health Centre. It is in Bob’s Park named after the local man who led the transformation of derelict wasteland into a green space, which has become a haven. The Health Centre is a model of integrated health care.

We met Andrew Mawson who was the church pastor who played a lead role in the regeneration of the run-down community. Andrew seemed without doubt to be a charismatic, visionary leader. He talked about the stifling bureaucratic red tape and the need to break rules, to get anything done. In his book ‘The Social Entrepreneur’ he also describes how he was impressed by the businessman Paul Preston who successfully brought the McDonalds chain to England. Mawson says ‘the devil is in the detail’ and describes how Preston succeeded by first of all focusing on every practical detail in just one shop, down to exactly where the milk came from and how long it took to be delivered. This shows an understanding from the top of how the reality of the work and what is required has to be integrated with the vision. The question isn’t so much about styles of leadership and management, whether it is either or, but about successful integration between the two.
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Siegel, D.J. (2006) Series Editor’s Foreword, in, Ogden, P., Minton, K. and Pain, C. *Trauma and the Body*, New York: Norton


An interesting brief video [https://goo.gl/T6tNNV](https://goo.gl/T6tNNV) with Andrew Mawson talking about social entrepreneurism and the challenge of creating something positive out of a nearly bankrupt economy as he put it.

“I think the most important issue is learning to work together, actually, and building teams of people who understand how to do that in creative ways. Because we have all got to move out of the silos that have been put down for us by the public sector and they are often there in business, and learn how to join things up.”

Dr. Dan Siegel video - On Integrating the Two Hemispheres of Our Brains, [https://goo.gl/sARWjq](https://goo.gl/sARWjq)
The American Psychiatrist and Neurobiologist Daniel Siegal (2006) claims,

“The central idea of interpersonal neurobiology is that integration is at the heart of well-being.”

In this blog, I am going to explore the relationship between integration and connection. The relationship is critical to health and well-being. This is the case in ordinary human development and also in the recovery from developmental disturbances, such as those caused by trauma in childhood. Siegel and Solomon (2003) state that effective therapy for trauma involves the facilitation of neural integration.

In part one of this blog, I referred back to the original use of the term integration in relation to child development, by Donald Winnicott, the British child psychoanalyst and pediatrician. According to him (1962) the infant is born ‘unintegrated’. Through the process of his fragmented experiences being held together by the ‘good enough’ parent, he achieves integration and a distinct sense of being a whole person. This normally happens by the end of the first year or so.

Child development is centred on the integration of emotional and physical aspects of relating. For this to be achieved the primary caregiver must be integrated as a person, but also connected within a wider environment. Ideally, there are positive connections with partner, family, and community. These connections provide the holding environment within which the caregiver and infant connect physically and emotionally.

While the uses of the word integration by Siegel and Winnicott, come from different perspectives and with 50 years in-between, the essence is the same. A healthy person is an integrated person. If we think of the developing brain we can think of neurons connecting and forming integrated neural pathways. Or we can think of different parts of the brain, connecting and functioning together in an integrated way. We can think of mind body integration. Integration of our senses with our mind and conscious awareness. Integration with the world around us.
From the beginning of life integration is interwoven with attachment. Referring to the importance of attachment in relation to the process of integration, Stien and Kendall (2004, p.7) state,

“Moreover, it has received influential support in the last two decades from neurobiological research which has found that secure attachments produce a growth-facilitating environment that builds neuronal connections and integrates brain systems.”

What enables an infant’s mind, body and brain to develop is connection with others. Throughout our lives development takes place within a relational context. As Bessel van der Kolk (2014) says,

“Most of our energy is devoted to connecting with others.” And, “We are profoundly social creatures; our lives consist of finding our place within the community of human beings.”

During infancy the attunement and emotional regulation of the caregiver is central to the developmental process. Mirror neurons in the caregiver and infant connect with the detail of each other’s feelings and behaviour. The infant’s neurons fire, connect and become wired. This kind of connected being 'in tune' with the other is called attunement. Just as attunement facilitates development, a chronic lack of attunement prevents connections developing and disconnects those that have. Neuroscience has confirmed how vital attunement is to this process, and Bessel van der Kolk (2014) states that “Donald Winnicott, is the father of modern studies of attunement”. This integrative statement helpfully connects the fields of psychoanalysis and neuroscience and also the past with the present.

It could be said that connection is the glue that enables integration to take place. Different parts become integrated because they are connected together. For example, a person with an integrated sense of their identity can connect the different parts of their life. An integrated and coherent autobiographical narrative, which is such an important indication of mental health is one that is connected. Like a story with a beginning, middle and end, the different parts are joined together coherently.

Where there is a lack of such connection during infancy, development is disrupted. As a result, the infant might not reach the developmental stage of integration. He could be described as unintegrated or unconnected. The unintegrated traumatized brain is not functioning together as a connected whole. Parts are fragmented, split off, closed down, not developed, dissociated, etc. Dissociation, which is a central feature of trauma, literally disconnects a person from himself and the world around him. The disconnection is a form of protection and it usually happens in terrifying situations from which there is no physical escape. Traumatized people are often disconnected from their bodies. The body is a source of pain rather than pleasure. It also let the person down by not aiding his escape from trauma.

Among many negative impacts on the brain-body system, trauma interferes with the integration of left and right hemisphere brain functioning. Rational thought cannot be accessed in the face
of overwhelming emotion. Emotional and social disconnection can begin a spiral that leads to further isolation and alienation. On the other hand, emotional and relational connection creates a positive spiral. It leads to the conditions that bring more connection.

An unintegrated person can’t disintegrate because there is nothing to disintegrate from. In the same way an unconnected person cannot become disconnected. However, an integrated person can disintegrate and a connected person can disconnect. If a person is traumatized, it is important to determine the point that recovery must begin from. For example, is it necessary to build connections for the first time or to heal those that have been broken? The answer can be reached through an assessment and understanding of attachment relationships and developmental milestones.

The reality of trauma means that the traumatic experience is not integrated into the personality, regardless of the person’s stage of development. The trauma is disconnected from consciousness but remains present through disturbing and frightening physical sensations, flashbacks and nightmares. One of the aims of treatment is to enable connections to be made between these sensations and the events they are related to.

“Individuals who lack emotional awareness are able, with practice, to connect their physical sensations to psychological events. Then they can slowly reconnect with themselves.” (van der Kolk, 2014).

The building of connections is central to recovery. This work can be considered on different levels. The individual’s connection with himself, his own body, his thoughts, sensations and emotions. His connection with others and the world around him. Connections between the different parts of his history and identity.

I am highlighting the importance of connection though the complexity of this work cannot be done justice to here. Before connections can be achieved, safety must be established. Only when the disconnected or unconnected person begins to feel safe will he be able to take the risks involved in connecting. Once the process of connecting begins the person is moving towards integration. The foundations of well-being can be considered as safety, connection and integration.

The third part of this blog will consider the need for integrated and connected systems and environments for trauma recovery.
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We as therapists are not really "shrinks"; we are "integrators". – Nelson, et al. (2014)

In the previous two parts I have discussed: the concept of integration in child development; the need to integrate management and therapy; how integration as a concept spans over 50 years from the psychoanalytic tradition of Donald Winnicott to the neuroscience perspective of Daniel Siegal among others; and how connection is central to integration and our well-being.

If neural integration is as Siegal says at the heart of well-being and trauma disrupts healthy development, then recovery is about completing the process of integration. A person or any living system that is integrated is one where the different parts work together in a functional way. For individuals there is mind-body and sensory integration, and an effective balance where emotion and reason complement each other. The same analogy can be applied to social groups, such as families, teams, communities and societies.

For children who are traumatized during the first year or so of life, integration may never have been achieved. For others who had more healthy early development the task may be about repairing disintegration brought about by trauma. Children who have suffered complex trauma need a healing approach that includes all aspects of their daily life. This is a total environment whole systems model. The same principal may also be relevant to many seriously traumatized adults. This is especially true when the trauma(s) took place in environments where disconnection, conflict and dysfunction were predominant.

The aim of recovery is to create connections that can be personally integrated. Connections can be thought of in relation to oneself, between internal and external worlds, in relationships with others, and the wider community. The level of connection that traumatized children need means that those who are involved in the therapeutic work must be highly attuned. Emotional attunement is receptive to connection and creates secure attachment. The mirror neurons of a baby will begin to connect with an attuned caregiver from birth. The primary carer-infant
relationship is of central importance as is the network of connections surrounding it. In the healing of trauma, just as in ordinary development ‘it takes a village to raise a child’. Or as Perry and Szalavitz (2006, p.231) said,

“What maltreated and traumatized children most need is a healthy community to buffer the pain, distress and loss caused by their earlier trauma. What works to heal them is anything that increases the number and quality of a child’s relationships.”

Networks of connections provide a potentially stronger level of support and emotional containment. This powerful network is then internalized and integrated by the child as part of his internal model. A good support network is the single strongest protection against becoming traumatized (van der Kolk, 2014, p.210). The architecture of the brain comes to represent the architecture of the social environment.

“What secure attachment promotes neuronal connections, helping to strengthen and integrate key brain structures.” (Stien and Kendall, 2004, p.8).

I was fortunate 30 years ago at the beginning of my career to find myself working in a therapeutic community where integration was the central focus of the work. Our task was specifically stated as to enable emotionally unintegrated children to achieve integration. The model of the community’s approach was also strongly based on the belief that the way the organization functioned as a whole was key to the children’s development. All relationships and roles in the community were considered part of the healing environment. The role of the maintenance staff and domestic assistants were considered equally alongside the work of teachers, care workers and therapists. This is one of the features of trauma-informed environments – everyone’s role is important and therefor needs to be integrated into the system as a whole.

Einstein’s view that ‘example isn’t another way to teach it is the only way to teach’, provides a good principal for how we approach the task. If integration is the aim of trauma recovery then we have to practice integration in every aspect of our work. To begin with, the adults who are working with such complex children and young people, need to have a reasonably robust level of personal integration and resilience. The team working with the child needs to be integrated and coherent. Different disciplines need to work together rather than compete. The whole organization - leadership, management, care, education and therapy must work together. The relationships with other stakeholders, such as referring agencies, families, local government and community also need to be integrated. Achieving all of this is a daunting task, not least because traumatized people tend to create further disintegration and disconnection rather than integration and connection.

A lot of this work to do with integration is about making and sustaining positive connections. Connections with the children, with ourselves and our histories, with our colleagues, with external agencies and the local community. To help think about these different levels of integration I will return to the work of Andrew Mawson who I referred to in my first blog
on this subject. He is a social entrepreneur involved in the regeneration of communities in the East End of London.

As well as being a social entrepreneur it could be argued that in essence Mawson is an integrator and connector. For example, in Bromley-by-Bow he integrated health and social issues. The Bromley-by-Bow medical centre became a place where people didn’t just go to see a Doctor, but to join groups and meet. Neighbors from different ethnic groups began to talk to each other, sometimes for the first time in decades. Elderly patients, joined art classes and other social groups. As people became connected the community as a whole began to develop and lift itself out of decade’s long decline, deprivation and depression.

When the 2012 Olympics were awarded to Britain money was invested in developing a water city. After the docks and associated industries had closed, the old river and canal system of London that used to be the lifeblood of the community had become unused and derelict. Ironically the once vital water system now became a barrier that kept communities apart and isolated.

Eric Reynolds, Founding Director of Urban Space Development, talking of the water city project says,

“A key part of what we’ve still got to do is create a sense of connection. Again, if you go up this wonderful river westward you will find bridge after bridge, after bridge, after bridge........If you put a road in there is a tendency for stuff to happen. Now London has expanded because of those life lines.”

Andrew Mawson continues,

“If you join the dots, that is a new city. And if you connect science and technology in an integrated way into that, that’s a very exciting opportunity for jobs and skills for people of East London over the next 25 years............The story is about recognizing these development nodes and understanding that if you fly into city airport and look down from an airplane all you will see is water. And you will see the six and a half miles of waterways that connect the royal docks to all these development nodes.”

A personal part of this for me is that while I was working in an organization providing a therapeutic service for traumatized children, I also spent an inspiring few days in Bromley-by-Bow. This was a part of training in strategic
leadership. On reflection, I am struck by the parallel of the importance of connection and integration on both the micro and macro levels. It is central to the micro level of individual recovery from trauma and to the macro level of community regeneration. It is also interesting that the language of social entrepreneurship and neuroscience meet together.

Both the individual and the community are plastic, i.e. capable of recovery and growth, however difficult and traumatic their histories. Just as neural pathways develop in the brain and build a network of connections, the building of bridges in the water city symbolically represent a pathway to new growth. In work with traumatized children both the micro and macro levels are important, but it is when there is a synergy between them that there is greatest potential for recovery. For a child this synergy would be like having a safe and attuned relationship with a primary carer, within a healthy partnership between parents, within a caring extended family, within a safe and thriving community.

A significant part of my work in recent years has been in developing therapeutic models in residential and foster care for traumatized children. Strong models are ones where everyone whatever their role is involved in the process of integration and connection. For example, a therapist might be doing what Siegal recommends – working to improve the integrative functioning of a child’s prefrontal neocortex. While the task of the organization leader might be about building integrative connections inside and outside of the organization.

One of the main satisfactions for me in my work is in helping organizations create models that integrate different perspectives in a way that is culturally sensitive. In 2011 I co-authored a book with the Lighthouse Foundation who work with homeless young people in Melbourne, Australia. A recent review (McNamara, 2015) said,

“In Australia, the most clearly articulated model of Therapeutic Residential Care is that offered by the Lighthouse Foundation (Ainsworth 2012; Barton, Gonzales and Tomlinson 2012) that owes much to the Cotswold Community in the UK.”

Before I began working with Lighthouse they had integrated into their model, some of the Cotswold Community’s therapeutic approach where I started in 1985. This is an excellent example of how different perspectives from different times and cultures can be successfully integrated. Another review of the book (Steckley, 2013) said,

"From the introduction through the final appendices, I was struck by the constant and integrated presence of thinking, feeling and reflection as integral to meeting the needs of young people, whether at an individual or organisational level..... This book offers vision and motivation to those with requisite courage to work towards a more humane system of care for children and young people............Elements of neurobiological and social ecological theories of development, the Sanctuary Model, organisational psychology, systems theory and even anthropology are also well integrated and usefully applied at relevant points throughout the book."
The very process of creating therapeutic models if they are to be of any use to traumatized children who need to become integrated and connected, also needs to be one of integration.

My three blogs on integration have moved between the micro level of the individual brain to the macro level of leadership, organizations and society. While this might seem a little awkward I think it is essential. We can’t consider the individual as an isolate. We are all part of a wider system. Well-being is about the integration of the individual, relational and collective levels (Prilleltensky, 2006).

References
The quotes by Eric Reynolds and Andrew Mawson are on a video on this site, Water City CIC, Connecting People, Business and Place, [http://www.water-city.com/](http://www.water-city.com/)


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The Meaning of a Child’s Stealing and Other Antisocial Behavior

Of course this is a complex subject and there is a risk of making simplistic generalizations. So the aim is just to give some food for thought that may broaden our perspective. The circumstances for each child and young person are unique as is the potential meaning of their behavior. That in itself is an important starting point – all behavior has meaning, however bizarre and bewildering it may seem.

What prompted me to write a blog on this subject was a comment by a psychologist, who said to me, ‘That while culture has a significant influence on behavior, stealing seems to be a universal theme across cultures, for children who are in care’. She wondered why?

Early on in my work as a care worker in a therapeutic community for boys who were severely traumatized by abuse and neglect, I was introduced to Donald Winnicott’s (1984) concepts of the 'Antisocial Tendency' and 'Delinquency as a Sign of Hope'. These concepts were especially helpful then and they still are now.

The children’s behavior in the therapeutic community could be extremely antisocial. The concepts provided a framework within which something comprehensible could be made out of what often seemed incomprehensible. Initially a few simple points helped. Children who have been abused, hurt, rejected and who don’t trust adults will relentlessly test the patience, stability and reliability of anyone who tries to care for them. This can be perceived as a necessary survival mechanism the child uses to hopefully arrive at the point where someone does survive him and becomes trustworthy in his eyes.

Unfortunately, many adults don’t ‘survive’ and either they or the child has to leave, so the pattern of rejection continues. Each time this happens the problem is made worse for the child. So the adult’s survival is essential! This is the case not only for an individual working with the child but also the team. The child will also test the ‘family group’s’ ability to survive together. Within the context of this difficult and often unpleasant work it can be seen there is a seed of hope. It would be more worrying if the child gave up and became completely withdrawn. Usually if a prolonged period of testing and challenging behavior is survived, the child settles and begins to accept the care he so desperately needs and wants.
Before beginning work in a therapeutic community I had never seen any specifically unusual behavior in children. Plenty of ‘children being children’, but nothing out of the ordinary. In the home I began in, much of the behavior was extremely unusual to me. One young person would eat the stuffing out of his bed cushions and had an obsession with the sewerage system. Another used to get out of his bed and sleep in his cupboard. Another ran off one night, found some old tins of paint in a shed and emptied them in a decorative pond. I’m not sure we ever figured out exactly what the meaning of that behavior was! Winnicott (1967) urges caution in expecting such a child to explain his behavior,

“The aggression is liable to be senseless and quite divorced from logic, and it is no good asking a child who is aggressive in this way why he has broken the window any more than it is useful to ask a child who has stolen why he took money.”

With the boy, the paint and the pond, maybe it was just a series of random opportunities and impulses. However, the pond was in the center of the community so the fact that the water had turned a whitish color could not be missed in the morning. Ward (2011, p.5) gives a general explanation,

“In the first place this search for boundaries may be shown in the family, and in the form of stealing, disrupting, or doing other things which will draw attention to himself, giving him some sense (however negative) of agency in the world.”

The young boy had certainly gained everyone’s attention and maybe that was what he needed. However, an incident like this can easily go wrong, especially if the pond had fish in it, which it actually did! The consequences of the action can become a bigger nuisance than the child intended. And instead of helping him to be understood which may have been his hope, causes a harsh reaction without understanding. Winnicott (1956, p.309) explains the nature of the difficulty and the hope,

“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.”

As Winnicott explained, it can seem ironic that just at the point when things begin to feel hopeful the child’s behavior can appear to get worse. On this occasion we did manage to tolerate the boy’s behavior and work with him in a positive way. Often thinking about why a child did something would offer some useful insight. This kind of thinking about meaning is central to the psychodynamic approach. Comparing this with a cognitive approach and a focus on developing strategies to manage behavior, Schmidt Neven (1997, p.4) says,
“However, in using a psychodynamic approach, one would view the problem in a different way. First of all, one would postulate that the destructive behaviour is in itself an important communication. It might, in the context of the family, be the only way in which the child is able to communicate something about what he or she feels. So we would ask the question ‘What lies behind the destructive behaviour?’ The other question we would ask is ‘Why does this behaviour emerge at this particular point in time?’ So the questions ‘What does it mean?’ and ‘Why now?’ are all-important.”

Adrian Ward (2011, p.4) wrote about Winnicott’s concepts and considered them in relation to the riots that took place in England during 2011. In reference to Winnicott he states,

“The first thing to be clear about is that he sees the antisocial tendency as being universal: in a refreshingly ‘normal’ way he acknowledges that every child has, in effect, both social and antisocial tendencies. At this point I must ask those readers whose own childhood was without blemish to ‘look away now’ – those who never deliberately swore, broke anything, shouted at their dear mother or pushed their sibling off his or her perch from time to time.”

Interesting that Winnicott, as the psychologist I mentioned, also referred to the antisocial tendency as universal. One of the tasks of being a parent or carer as Ward and Winnicott point out, is providing the child with clear and appropriate boundaries. At the same time it is important to recognize and have empathy for the fact that healthy development requires the child to push against these boundaries. Sometimes the child might need to go over the boundaries to experience what it is like on the other side. The child psychotherapist Adam Phillips (2009), in his paper ‘In praise of difficult children’, explains the paradox this creates,

“The upshot of all this is that adults who look after adolescents have both to want them to behave badly, and to try and stop them.”

Antisocial behavior becomes a more worrisome problem when it isn’t responded to and contained within the family or caretaking setting. The child in this instance is then likely to seek boundaries outside of the family home. Still, there may be an underlying hope within the child that his behavior will alert his primary caregivers.

Ward explains,

“It is as if, in Jan Abrams’s words, ‘the individual is searching for an environment that will say no – not in a punitive way, but in a way that will create a sense of security’ (Abrams 1996 p.54). This is largely an unconscious search of course, in which the child is repeatedly driven to seek out something which is instinctively felt to be missing.” (p.5)

Many parents will have received the occasional cautionary letter from the school principal or even police, and this has been enough to alert the parents to the child’s needs whatever they may be. However, when this type of scenario isn’t responded to well the child’s behavior may worsen. Over time he may become hardened to living in a world where he feels his needs can’t
be understood and met. He may then begin to seek ways of gratifying his own needs. The antisocial behavior may take on a secondary gain, such as feeling excitement, power and delinquent status. Dealing with this problem is far more difficult and highlights the importance of noticing and responding to signs of antisocial behavior early on.

This brings me back to the issue of stealing and why it is often one of the first acts of the antisocial tendency across cultures. One universal fact regarding child development is that a child cannot grow and develop, without something good and nurturing from adult carers. The child has an instinct for this and behaves in such a way as to illicit the positive response of a carer to his needs, normally the mother to begin with. This has been called 'attachment seeking' behavior. When a child loses something that felt good, however short or fleeting it was – he is deprived and wishes to return to the positive state that has been lost. Adam Phillips (1988, p.17) in his book on Winnicott explains that when a child in this situation steals he is not specifically interested in the 'thing' he steals. He is stealing ‘in symbolic form only what once belonged to him by right’ and which has been lost. He is also ‘alerting the environment to this fact’ and testing the environment’s tolerance towards the nuisance value of such behavior (Barton, Gonzalez and Tomlinson, 2011, p.95). This type of stealing can be understood as an unconscious impulse. It is such a primitive instinct that it can be expected to be a universal phenomenon of childhood deprivation. Maybe even the word stealing is not appropriate as it is so easily misunderstood in a negative judgmental way.

Often the most helpful way to respond is to consider that the child may be looking for his needs to be met within the context of a nurturing relationship. In my experience, once this happens the ‘antisocial tendency’ is likely to disappear at least to what is within the realm of ordinary child development. Ward concludes that the concept of the 'Antisocial Tendency' and 'Delinquency as a Sign of Hope',

“...was and still remains one of Winnicott’s most remarkable and profound insights...” (p.7)

References


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Adrian Ward’s free pdf paper can be downloaded here, http://goo.gl/WUwLoq

I just found this blog below and think it might be those who are interested Winnicott. It does strike me how much some of his concepts still resonate so powerfully. This is on the ‘Good Enough Mother’, which I have often found to be a salvation! http://goo.gl/nKxO9i

Comments

Gulchekhra Nigmadjanova, Advocacy Advisor at SOS Children’s Villages, Uzbekistan

I opened for myself Winnicott’s Good Enough Mother book. CRC says exactly the same about parenting. And this is something many of us parents live with and apply in bringing up. For there is such a devoted mother or someone dear behind many successful children and adults too. How to raise understanding of this parenting, how to empower parents - of own or foster or care givers to treat their children using this attitude and approaches - this is an issue.

Moses Wangadia, Programs Team Leader at Retrak, Uganda

I like the phrase deprivation. Working with street children in a long time I have seen and heard parents complain about their children becoming thieves and hence ending up on the streets. But what I have learn t about this is that it starts with a child being denied food at most because the child doesn’t want to work which is the order of the day in most homes where children contribute or participate at home in certain areas. Once this happens, the children are left with no option but to start looking out for where to get food and certainly having no source of income the easiest way out is to start sneaking to get what to eat either from home or around the neighborhood. Unfortunately in doing this, some learn t that there is an easy way out where you don't work but get what to eat and it becomes a behavior. All this at a certain level has elements of deprivation. However, what I need to figure out is what causes someone to be averse to working or following instructions at home that lead into this deprivation. If it doesn't still lead to deprivation of parental attention.
Bonnie Murphy, Consultant, Autism / Child Abuse Advocate, USA

Excellent article for both clinicians and caretakers (parents/guardians) of children who display antisocial tendencies. My viewpoints are from the parent side, by no means am I professional, except in the way of "school of hard knocks" as I go on a journey with my son who has antisocial tendencies. I agree with you; that stealing is almost always universal among children who have been abused, traumatized, hurt or rejected.

Loved how you Referenced Donald Winnicott's (1984) 'Antisocial Tendency and Delinquency as Sign of Hope,' was especially interesting and his concepts appear to hold true 30 years later: Abused, hurt, rejected children tend to not trust adults and will test patience, stability, and reliability of anyone who tries to care for them. When a child steals an item, the item represents something of loss - it's a subconscious impulse.

Another vital concept by Winnicott; A child tests the 'family group's' ability to survive together. Searching for boundaries in the family, form of stealing, disrupting, or doing other things which will draw attention to himself - giving them sense of control. The child may or may not know why he is doing such behaviors only that it is self-soothing in ways that most people cannot understand. Over the years I have concluded that children of trauma, abuse, neglect, abandonment and rejection are only comfortable in chaotic environments - if no chaos, they will create even though it was what they hated when in an actual unsafe chaotic environment. It seems that breaking this pattern is most difficult. My favorite concept Winnicott illustrates is '....the treatment of the antisocial tendency is not psychoanalysis but management....' This supports Jan Abram's words when she wrote about Winnicott's work: '...the individual searches for environment that will say NO - not punitive way, but way that will create sense of security....' Which comes back around to your concept: '.....One universal fact regarding child development is that a child cannot grow and develop, without something good and nurturing from adult caregivers....'

The flow of all incites; Winnicott, Abrams, and yours highlight very important concepts that all caregivers should be aware of. Families need access to such information / training when dealing with antisocial behaving child - it is a vital part of the child's success as he learns to trust society. I reiterate; I speak from personal experience, having dealt with these issues with my 12-year-old son for last eight years - we were completely blindsided by all these behaviors and many more. We knew that adopting an older child would have some issues but never in our wildest dreams could we have foreseen what we have gone through as a family.

Patrick Tomlinson

On the subject of the universal nature of ant-social behavior!

“I would there were no age between sixteen and twenty-three or that youth would sleep out the rest; for there is nothing in between but getting wenches with child, wrongdoing the ancentry, stealing, fighting.” Shakespeare, A Winter’s Tale, 1623

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The Importance and Value of ‘Being’

For many of us, this time of year (holiday season) is a time for ‘being’ with each other and a temporary stop in our often frenetic lives of doing. It can be a special time of being with those to whom we are closely bonded by family and friendship. However, as this potential opportunity is often at odds with our regular day-to-day life and work experience, we might just replace one kind of frenetic activity with another, such as excessive consumption!

The advent of a new year can be a time of reflection, which again can also be obliterated by hyper-activity under the name of celebration. It seems an appropriate time to write a blog on the subject of the value of being, as opposed to doing. The capacity to reflect has been shown to be hugely beneficial to our health, especially when it is built into daily life. I even read recently that a study claims the regular habit of writing in a reflective way can improve the speed of recovery from some illnesses and injuries. Reflection can reduce stress, which improves the immune system, etc.

Increasingly, we hear about the value of reflection and concepts such as mindfulness are becoming familiar. The principles involved are not new and can be traced back thousands of years and are embraced in many fields, such as Buddhism. In terms of child development and of healthy adult capacities, the ability to reflect, to think about oneself, and to consider what others might be thinking about oneself is an essential part of being able to relate to others. Some researchers have argued that the ability to reflect on one’s experiences is a greater indicator of health than how much adversity one has experienced. As Kezelman and Stavropoulos (2012) who have created excellent guidelines for trauma-informed services, state,

“It isn’t just what happened to you that determines your future – it’s how you’ve come to make sense of your life that matters most.”

Digesting and making sense of experience requires a degree of allowing ourselves to be, to ‘sit with’ and to feel. Whereas, busily doing can be a distraction and a way of avoiding feelings and thinking. As a result, the avoided feelings and experiences associated with them, remain unprocessed and therefore unintegrated into our personality. The feelings are inaccessible as any kind of useful guide or resource for the future. Learning from experience comes to a halt and therefore so does development.

Interestingly, I started a discussion on this subject on my LinkedIn group in January two years ago. I wonder whether the timing of the New Year is coincidental. The quality of discussion was excellent and I think partly because the theme is so universal and not just relevant to our work with traumatized children. Some of the comments made by members of the group show how much this subject resonated with them,

“Imagine that, listening to understand rather than to just respond (teach/tell/direct) - incredible!” (Ian Nussey - Australia)
“…my role was just to be there listening.” (Lorna Miles - UK)

Ian responded – “The special ingredient Lorna - genuinely being with…..”

“The opportunity for free play, space and being with each other and adults was hugely important.” (Judy Furnival - Scotland)

“……..being new to therapeutic care in a residential environment my strategies are at times very basic in the way that I go in and just be me in a relaxed manner as opposed to some that just need to be completely planned throughout each minute of the day which in my opinion leaves no time for proper self-reflection.” (Aaron Hamill - Australia)

“In today’s society, every minute of every hour is organized which leaves very little time for children to be creative. ......Always organizing their free time is not the best thing for helping children develop creativity, self-regulation and imagination. (Sylvie Demers - Canada)

“I agree that children need time to be rather than do. The problem, as I see it is that some children don’t know how to be except within a trauma framework. Their frenetic activity might be a way of avoiding thinking and being.” (Christine Gordon - Scotland)

With a group of young people I worked with, we used to plan our evening activities in a meeting after tea. The usual things offered, would be soccer, cricket, bike rides, walks, card games, crafts, swimming, etc. I decided to offer that I would spend a half hour or so ‘being’ in the living room and those who were interested could ‘be’ with me. Naturally, this aroused curiosity as to what ‘being’ involved. I explained something like, just being together, chatting, playing if people wanted to, maybe listening to music, etc. It was less structured than usual, though still with some boundaries. After a while, being became a popular thing to do – if that isn’t a contradiction! A general feeling of safety is necessary for this kind of possibility to develop. I enjoyed these times and over the years have found that girls are better at this than boys – though I might be generalizing from a little experience.

Being rather than doing can be difficult as it allows time to think and feel. For people who are traumatized thinking and feeling is often frightening. Thoughts and feelings must be kept at bay and one way of doing this is through frenetic activity as Christine described above. The world of these children can become a desolate place without emotion. Being rather than doing, conjures up possibilities. There is a sense of uncertainty and not knowing, a lack of control. To a healthy person this might be challenging but also potentially exciting - to a traumatized person it might be terrifying. Anyone who is close to a traumatized person is likely to pick up this fear and coupled with their own, can easily be swept into a whirlwind of activity as a form of avoidance. In the world of ‘therapy’, especially psychoanalysis it is stated how important it is for the therapist to tolerate a sense of 'not knowing'.
The concept of Negative Capability coined by the poet John Keats back in 1817 is often referred to. Keats described negative capability as the art of remaining in doubt "without any irritable reaching after fact and reason" and "the willingness to embrace uncertainty, live with mystery, and make peace with ambiguity".

The British psychoanalyst Wilfred Bion elaborated on this, describing negative capability as the ability to put aside preconceptions and certainties, and tolerate the pain and confusion of not knowing. More recently the child psychotherapist and psychoanalyst Adam Phillips in discussing parenting has said,

".....that the parents, the authorities, are at their most dangerous when they believe too militantly that they know what they are doing."

Why is this subject of ‘being’, which allows the space for something unknown to unfold, so important? I think the key reason is that it is central to the process of our development, as individuals, groups, and societies. How we are able to be with ourselves individually and collectively is fundamental to our health. An infant is born into the world with a distinct lack of ability to be with and tolerate different emotional states. Anything that causes distress requires someone else to be with them, and to emotionally contain the distress. As Donald Winnicott said, there is no such thing as a baby, there is a baby and someone.

The critical issue is what that other person does with the difficulties involved. Is she/he able to tolerate the feelings involved and to think about the infant or does he/she also find the distress intolerable and feel the need to only take it away?

The difference for the infant may be between a helpful/thoughtful response, a relieving/thoughtless response and an unrelieving/thoughtless response. The first changes the infant’s experience in a way that might also encourage him to develop his own capacity to think about his feelings and hence find thoughtful solutions to difficulties. The second might relieve the infant of his distressing feelings, but in a way that discourages thinking and encourages dependency on a quick fix. This is about taking away the distress rather than developing the capacity to sit with it and find constructive solutions. The third just makes matters worse for the infant and is likely to lead to the need for defensive protective measures, such as switching off from emotions.

An important question is whether distress or ‘psychic pain’ is perceived as something to be got rid of and/or relieved, or whether it is something primarily to be understood in a way that makes it tolerable. This question is often highlighted as the difference between parents, who are motivated by the desire to relieve their children of pain and those who are more on the side of
helping their child learn to manage painful experiences. The same applies in other aspects of life, professional and personal. Do we want to rescue another from pain and difficulty, or be alongside them as they find their own way? These dynamics are well known in our profession in the form of victim/perpetrator/rescuer. The media also portrays images of leaders as heroic figures coming to the rescue, with the answers to fix a problem rather than as people who work alongside others to find solutions (Ward, 2014). We can all wish for a ‘magic wand’. Sometimes a solution might not be possible and it is more about finding the best way to live with the ‘problem’.

There may also be a cultural tendency to view all depressive feelings as a problem to be got rid of or solved. As one child who had suffered many difficulties that he had the need to feel sad about, said to me, ‘I need cheering down, not cheering up’. Facing real and painful issues rather than avoiding them is how experience can be integrated into our identities in a way that furthers our learning, understanding and development. Difficulty in being able to tolerate any pain or frustration is likely to hinder development.

Whether we are working directly with a child, or in a management or leadership role, resisting the temptation to become the problem solver can be difficult. Our need to get out of the difficulty and to relieve our own anxiety can be the primary motivating factor, rather than the development of the person(s) we are with. Generally, working something out oneself with the support of another is a more useful outcome than another working it out for one. It is hard to be alongside someone who is struggling, needing time and making mistakes. The external environment where others may hold us responsible for the outcome can add another layer of anxiety. It might be felt that it is too risky to allow a mistake to happen, so the possibility is preempted.

The child and adolescent psychotherapist Margot Waddell (1985) has referred to the different ways of responding to human difficulties as one between ‘serving’ and ‘servicing’,

“The difference between the two modes might be made by the mother who serves, by being available by 'thinking' emotionally, as opposed to the mother who services by doing instead of thinking.”

Waddell elaborates that “servicing nearly always implies action, with very particular overtones” whereas serving “may constitute not doing anything”. However as she explains, “not doing anything does not constitute doing nothing”, and, “There is a 'world' of difference between 'standing by' and 'being a bystander'”.
It can be misguided to consider doing as active and not doing as passive, when often it is not doing that is the harder and most useful option. For example, how long can we or should we tolerate watching and encouraging a child who is struggling to do something? How much satisfaction does the child get when he or she achieves the task and thinks ‘I did that myself!’?

Waddell explains how these same dynamics can be transferred to organizations and societies. Where on a collective scale becoming ‘mindlessly busy’ is a way of avoiding the real difficulties we are faced with. Sadly, this also deprives us of the opportunity to understand those difficulties in a way that leads to growth. This tendency has been clearly outlined by social scientists, going back to the 1950s, such as Elliot Jaques and Isabel Menzies Lyth. These social scientists explained how organizations unconsciously develop defensive systems to protect themselves against the emotional pain involved in the task. For example, as Menzies Lyth so powerfully described, the task of caring for patients in hospitals includes primitive anxieties related to the themes of illness, loss and death. One way of responding to these anxieties, is to avoid them by depersonalizing the patient, and creating systems which don’t allow ‘professionals’ to get emotionally close to the patient.

We may be familiar with the scene of a doctor talking to his students about the patient in front of him, who is referred to as a number, or such and such case! While this might help reduce emotional pain (for the doctor and students), unfortunately it does not aid the patient’s recovery. Emotional connection between doctor and patient has even been shown to improve recovery from the common cold (Rakel et al., 2009). Therefore a helpful solution would seem to be one that enables human connection between Doctor/Nurse and patient. However, an approach that recognizes the pain involved also needs to provide appropriate professional support.

It is often stated that modern lifestyle militates against the capacity to be in a moment without distraction. This is caricatured by the now familiar image of two people sitting supposedly together having a meal, whilst gazing at their mobile phone. I was in a restaurant recently and noticed a mother feeding her baby, moving her focus between a television and ‘smart’ phone. A few and increasingly rare owners of bars and restaurants refrain from the introduction of TVs, etc. and promote the idea that a place just to be together might be of value.

A comment made by a boy in the therapeutic community of Finchden Manor (1930-1974) captured the essence of ‘being’. When asked by a visitor, ‘what do you do all day’ – he replied, ‘I don’t know what we do, but it’s a fine place to be in’ (Harvey, 2006).
Tom Robinson the British musician-singer-songwriter who spent a number of years at Finchden Manor, claimed that it saved his life. **Talking about life at Finchden**, he said,

“As to what we did all day.... there was everything and nothing to do......you could just lie in the grass on the field staring at the sun reading a book......time seemed infinite......what Finchden offered you above all, ....it offered you respite, and there was a complete respite from all forms of nagging and pressure.”

Some visitors to Finchden were critical, saying that the staff seemed to do little but ‘watch the boys’. Finchden’s founder, George Lyward responded that watching is one of the hardest things to do in life. He explained that the staff look for when the boys come alive, nurture the boys’ talents and help them shape their future life.

Maybe it would be helpful for us to reflect upon why as Lyward said, this is so difficult – what gets in the way of allowing ourselves and the children we work with, to be? Comments most welcome – in the meantime – Happy New Year

**References**


Dr. Kezelman, C. and Dr. Stavropoulos, P. (2012) *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, Australia: Adults Surviving Child Abuse (ASCA), [http://goo.gl/t9o3IA](http://goo.gl/t9o3IA)

Link to the discussion on Therapeutic Residential and Foster Care for Traumatized Children, January 2013, [https://goo.gl/0jcw3i](https://goo.gl/0jcw3i)

Link to the interview with Tom Robinson about George Lyward and Finchden Manor, on the BBC Radio 4 ‘Great Lives’ series, [http://goo.gl/29lJfV](http://goo.gl/29lJfV)


Further reading


An interesting blog on the benefit and difficulty of being still, http://goo.gl/1tnupn

3 Blogs by Maria Popova,

"Young Delacroix on the Importance of Solitude in Creative Work and How to Resist Social Distractions", http://goo.gl/M7n01X

"Psychoanalyst Adam Phillips on Our Capacity for “Fertile Solitude”, http://goo.gl/i5SVJT

"Kierkegaard on Boredom, Why Cat Listicles Fail to Answer the Soul’s Cry, and the Only True Cure for Existential Emptiness", http://goo.gl/75vByp

Comments

Anonymous

Patrick, you have summarized an integration of existential and depth psychology. Gordon Neufeld addresses this same integration, speaking to both parents and therapists, urging them to understand the child's need to learn to recognize frustrating situations (not intellectually...not as a cognitive process per se) and respond differently by not doing anything except being there and allowing the frustration to provoke growth. The learning of that new response is adaptive giving the child a sense of power involved in finding an alternate response, otherwise known as problem solving. In my clinical experience I see the failure for this to occur with many adults and children who we could not say have been "traumatized" but can say, with Erikson, that they have failed to navigate the developmental crises with sufficient positive experiences to develop the
psychosocial virtue associated with each stage. Of course virtue involves choosing to act in a
certain way (doing) after being in a state of emotional conflict.

**Ioana Boldis, Psychologist, Romania**

Many good ideas in this blog, Patrick. I believe, as you said, that "being with" is very important. Even in therapy, people need this more than anything else. Because they need to learn by themselves. Not to receive instant solution. But they also need someone assisting them in developing skills for finding efficient strategies and solutions. It’s something like “be there with me in time of need and I’ll learn to calm down and get over it”.

An interesting thing that I’ve observed is that in the long term relationships, where “being with” is a frequent practice or routine, people start thinking as a single brain. No matter if we talk about romantic relationships or parent-child or other relationships, “being with” creates some sort of in-depth connection and resonance. I don’t know if it has to do with empathy, limbic system, mirror neurons or other variables, it just happens.

A good article about reflection and getting aware of what we need, not only about what we do.
Thoughts on the Attitudes towards Abuse of Children

This is a huge subject and I am just going to make a few comments about my experience. Though these experiences may to some extent seem random, I think they are also connected by a theme. My first experience of work with children who had suffered abuse and neglect was in 1985. I was shocked to see how their early lives had so terrorized and deprived them of the experiences essential for healthy development.

As a result of abuse and neglect a 12 year old child, might have the functioning level of an infant and may not even have reached the level of emotional or neural integration normally achieved in the first 1 – 1.5 years. These children’s development had literally been frozen. Their emotions were also highly dysregulated and they can fall into an overwhelming panic or violent rage in an instant. At the other extreme - still watchfulness, emotional detachment and withdrawal may be the predominant mode of functioning. One thing that surprised me at the time was the fact that children like this existed, as I had no idea. It was and still may be a human problem that is hidden away. I knew about various disabilities and their consequences, and there was plenty of media coverage – but nothing on these children traumatized by those who were supposed to protect them.

“The single most significant predictor that an individual will end up in the mental health system is a history of childhood trauma, and the more severe and prolonged the trauma, the more severe are the psychological and physical health consequences.” (Kezelman and Stavropoulos, 2012)

It has been said that the dynamics of abuse are secrecy and denial. Kezelman and Stavropoulos (2012) refer to the ‘culture of silence that continues to surround child abuse’. They give an explanation of why this may be so,

“The many constraints which still militate against open discussion of child abuse compound recognition and addressing of violations the scale and magnitude of which, were they to be acknowledged and confronted, would both raise questions of complicity and comprise grounds for deep national shame.”

I recently read that it was published in the 1950s that one in a million women had probably experienced incest as a child. Apparently the text where this was stated was still widely used in the training of psychiatrists in the 1980s. Some researchers these days put the incidence of child abuse within families as closer to one in four. Why is there such a huge difference in 50 years? Is child abuse on a huge increase or is it just being reported more, or both? We also know very well the historical controversies that have existed in the relational sciences, as to whether reports of child abuse by adults in treatment are real or phantasy.

“Professor Middleton comments that ‘if it is hard to find a comparable example in society where something so damaging to so many could exist undisturbed for decades under the gaze of those professional bodies who would be assumed to have qualifications and motivations to bring clarity
and to be at the forefront of addressing such a pervasive threat to the mental and physical health of fellow citizens.” (ibid).

On the one hand it seems that progress is made in the exposure of child abuse. But it doesn’t seem that it is becoming any less common. Some westernized countries, may have been ahead in terms of surfacing the problem. I was in India 7-8 years ago and sexual abuse was just beginning to be talked about in the media. Since then there has also been a big movement to expose the violence towards women in India. I gave a talk to 100 or so social work students at an Indian University. During the talk I referred to a child I worked with who had a severe panic attack when I made a simple request, like asking him to finish his breakfast. It turned out his mother had made a similar request and then hit him so hard on the head with a stick that he needed hospitalization. One of the students stood up and said she didn’t see why being hit caused the boy such problems in the future. She added ‘we’ve all had a good beating’ to which everyone laughed.

I explained that the beating, while some would argue is never good for a child, might also depend on the context to determine how much damage is done. For example, if the culture is one where hitting children is common, at least the child feels this is normal - my friends also get hit. Another factor might be whether the ‘disciplining’ action takes place in what is a generally loving family environment – where the parents are concerned for their child. Or is it part of a more neglectful environment where the parents’ actions are more based on their own difficulties rather than the child’s needs. The severity is another factor – violence that requires medical treatment cannot be right under any circumstances. While physical discipline might be considered by some to be ok within a cultural context, I don’t think that anyone would argue that sexual abuse is.

Maybe because it simply isn’t ok – having a discussion about sexual abuse tends to become difficult. Besides abhorrence towards the abuser, few other views are expressed. Sex offenders are routinely hated and despised, and portrayed as evil. I remember visiting a sex offender in prison. On the way to the prison the taxi driver was keen to know why I was making a prison visit. When I alluded to the reason, the conversation immediately ended. After the visit, I was wondering why the prisoner I visited came into the room, after the other prisoners, sat on his own, wore a colored band and left before the others. I realized it was probably for his own safety. Having anything to do with sex offenders or even children and young people who have been abused, can be uncomfortable and one’s motives might be questioned. This is highlighted by the difficulty that can be involved in having a conversation on the subject with someone who has been abused. Too much interest might be felt to be intrusive and voyeuristic. Too little might feel like turning a blind eye.

Recent sexual abuse scandals in the UK regarding, dead or elderly celebrities have caused an outrage. Some of the most popular family entertainers, it turns out had been abusing children. The outrage has been towards the individual perpetrators, followed by the organizations that failed to be sufficiently protective or even colluded. It is as if the moral outrage about abuse can be vented towards these cases, but we can’t have a rational discussion about what is happening in our own neighborhoods. A few years ago when I was opening a new children’s home in a residential neighborhood we met each neighbor so we could build a positive relationship. One
neighbor could not let go of the question, ‘but have these children been sexually abused?’ He was fearful of this, as if the neighborhood would be threatened and at risk by having an abused child living among them.

I focused on the fact that the children we were looking after all had needs due to their difficult childhoods and our job was to meet those needs, so that they could develop and prosper. The neighbor kept persisting with his question. In the end I said that according to the statistics maybe 1 in 10 of the children in this neighborhood were abused. After that he abruptly dropped the whole issue.

Thinking about the conversations with the neighbor and taxi driver, I am struck by the fact that I just allowed the conversations to end. I could have asked them their views on what I had said. Maybe the underlying feelings, such as, anxiety, fear and hostility led me to rather not talk and therefore collude in a small way. One of the inferences for anyone who is close to sexual abuse, whether personally or professionally, is that they may be complicit with the abuse. Therefore anyone who talks about it, rather than to just utter disgust towards a perpetrator runs the risk of being judged in a similar way. It is common in working with traumatized children, to be treated as if one is an ‘abuser’.

What I am suggesting with the examples above, is that the problem of abuse gets projected in an extreme way and this is part of the denial dynamic. I have come across many worthy organisations who aim to tackle the problem of abuse by focusing on the pedophile, ‘lurking on the street corner’. The emphasis on stranger danger continues, though evidence suggests that the most likely threat to a child is someone who is close to them, especially a parent. We educate young children on how to avoid being lured by a stranger. Do we educate children on what to do if someone in the family is abusive? Maybe this reality just touches upon too many taboos and challenges the idealization of the family that is prevalent in many cultures.


My understanding of Furedi’s argument is that the erosion of our trust in authorities leads to a high level of uncertainty, which makes us feel anxious. We then project some of our anxiety onto children, who are increasingly perceived to be vulnerable and ‘at risk’. Interestingly, numerous countries have gone through the same process in the last few years. Erosion of trust; exposure of corrupt politicians, church, bankers, etc.; media exposure of scandal in relation to child abuse; as the moral panic grows, there are then ‘witch-hunts’;
discovery of institutional abuse; national outcry and government inquiry; followed by recommendations on how to better protect children.

These are necessary and appropriate concerns. However, as Furedi argues our difficulty in really thinking about rather than reacting to the issues involved, leads to some very unhelpful and destructive actions. It also undermines the potential to make real progress. A slight illustration of a moral panic was when a pediatrician in Wales had bricks thrown through his living room window by an angry neighbor. Someone referred to him as a pediatrician, which was mistaken to mean pedophile!

Wrongful arrests are on the more serious side of things. I know of one service for children that was closed down, due to the wrongful accusation of a link with a pedophile ring. The sensationalized media headlines was followed by the withdrawal of children from the service. Two years later, after the service had closed, children unnecessarily removed, staff wrongly arrested and careers ruined, the Judge concluded the trial by praising the work of the service.

How do we know, when denial is appropriate and when it is a cover-up? Conspiracists might argue that Judges, Police, Politicians, Churches have a lot invested in supporting denial. This dilemma and lack of trust is exactly what Furedi suggests makes this such an important and difficult problem.

Ultimately, what we want is less children suffering abuse and the potentially devastating consequences. How will this be achieved unless we become more able to have rational discussions about the problem? How do we become more able to think about this difficult subject and what it means?

Reference

Dr. Kezelman, C. and Dr. Stavropoulos, P. (2012) The Last Frontier: Practice Guidelines for Treatment of Complex Trauma And Trauma Informed Care And Service Delivery, Australia: Adults Surviving Child Abuse (ASCA), This document can be downloaded here, http://goo.gl/t9o3lA

Comments

Sean Ferrer, Director - Strategic Marketing, England

Patrick, you have written a highly thought provoking, and courageous piece here. I use the word courageous, because the fashion these days is to portray all sex offenders as incarnate evil, so abhorrent that the mere mention of the label provokes a raft of negative commentary. The fact that you have not engaged in the standpoint is to be commended.

Neither you, nor I, condone such offences, but I feel we both recognise that progress in our understanding of the phenomenon of sexual offences, especially against children, is continuously impeded when it is drowned out by a collective wail of disgust. Moreover, anyone who fails to
express his or her own disgust when exploring the topic risks being branded in some way complicit, or supportive of such damaging behaviour.

**Jonny Matthew, Consultant Social Worker and Criminologist, Wales**

Good stuff, Patrick - very thought-provoking! Your comments about those who help being in some way viewed suspiciously, is very true. After many years working with harmful sexual behaviour in teenagers, I've experienced this many times. Worse still, at times, I've colluded with this suspicion by moderating my own comments in line with what I perceive to be the likely stance of skeptical others. I guess part of this is the desire to avoid "freaking out" the uninitiated!

Sean's point about the prevalence of sexual interest in children is perhaps the next taboo for society to assimilate. The thorny issue of sex offenders as victims with reactive behaviours is another. Not that this is permissive or excusing in any way. Neither is it remotely suggesting that all victims do or may become perpetrators - that would be ridiculous. But we do have to face the fact that those who commit sexual crimes were very often victims themselves - meta-analytic research is really clear on this.
I was recently asked by a health care professional if I thought that the terms compassion fatigue and vicarious trauma were still contestable. I am thankful for his question, which seems to have got me thinking and writing again after a period of blogger's block!

Up until relatively recent decades it has been contested whether exposure to armed combat and other seriously threatening situations is a definite cause of PTSD. During the last century various other concepts were put forward as an explanation, implying a weakness of character, a nervous disorder, a ‘fragile heart’ and even malingering as the more likely causes. In some cases the malingering concept was used to justify the withdrawal of financial benefits to war veterans, as the benefits were deemed to be fueling the problem.

Therefore, the idea that a person may experience compassion fatigue or vicarious trauma, as a result of working with people in need would inevitably be contested. However, these days there seems to be an acceptance that the concepts are a reality that need to be taken seriously. Compassion fatigue and vicarious trauma clearly imply being involved with people, whereas the more general term burnout can be applied to most work situations. For example, a Truck Driver may be temporarily ‘burnt out’, by driving too many miles or hours without adequate rest breaks. A few years ago I was watching a market trader selling meat. Instead of the usual sales banter he started tossing meat out to the gathered crowd and complaining that he hadn’t had a holiday in years and had to get up at 5am every morning.

While we can see and agree to the reality of compassion fatigue, vicarious trauma and burnout, the specific language we use will frame the problem in a certain way, influencing how we understand and respond to it. A term like ‘compassion fatigue’ is one way of saying something about a certain reality. It is like a metaphor for something, but on its own does not explain everything involved.
It is completely incontestable that people have an impact on each other for better and worse. If someone spends most of their working day engaged with people, the needs and moods of those people can have a huge impact. Spending a few minutes with a highly distressed, traumatized person in an agitated state can quickly get under one’s skin. As, in a different way, can spending time with a depressed, withdrawn person. It can actually be a necessary and vital part of the work that we are able to allow the other to have an impact on us and get under our skin. Some young people I have worked with would not give up agitating and provoking until they got a reaction. They needed to know that they could get through and have an impact. Otherwise their sense of insignificance and worthlessness would be affirmed.

It is how the impact is responded to that is the critical issue for all involved - the worker, the ‘client’ or other and the wider context, family, team, organization, etc. The language we use to understand the problem will influence our response. If we use the term ‘compassion fatigue’ it suggests that the problem is caused by compassionately giving too much to others, who are therefore implied to be demanding. The term creates a focus on the demands involved, like maybe there are too many children to look after, maybe the caseload is too big?

However, as in all demanding, stressful and potentially threatening situations, different people respond differently. It may turn out that one person who has ‘compassion fatigue’ has been neglecting their own needs, maybe out of guilt or a lack of self-worth? There may be many different reasons. Looking at the problem from this angle, a term like ‘Self-Neglect Fatigue’ could be used. This would focus the issue more on the person suffering the fatigue and how he/she is managing the situation. This focus could become persecutory and unhelpful, especially if the fatigued person felt blame rather than empathy. It should also be added at this point that feeling upset, distressed and shocked among other strong emotions, are often normal, healthy reactions. However, when we are talking about fatigue it is the difficulty in returning to a sense of stability that is the problem.

A professional in the air flight business, gave the example anyone who flies on a plane will know. In the safety briefing, passengers are told that before fixing the oxygen mask on anyone else, including your own children, make sure yours is fixed first. In other words, we might need to look after ourselves if we are to be of any use to someone else. This can seem counter-intuitive as the natural reaction of a parent is often the other way round. The same can apply in the ‘human services’ where it might feel that self-care is somehow equal to neglecting the other, whose needs might seem overwhelming in comparison. Cultures based on guilt, self-sacrifice and martyrdom can become dominant.
This raises the further possibility of the context of support as another key factor. In this case, we could use a term like ‘Lack of Support Fatigue’. This term would create a focus more on the context, family networks, professional support, organization culture, etc.

In reality, all of the above factors are related to any one situation. It is the interplay between them that needs to be understood and worked with. I think we do need to be aware of how language tends to frame how something is understood and thought about. A helpful way of thinking is one which encourages all relevant parties to acknowledge the reality, consider its roots and take appropriate responsibility. A narrow approach might lead to a tendency to shift the responsibility in one direction, i.e. onto the 'client', the worker or the organization; or the child, the parent, the family or the community. As Isaac Prilleltensky (2006) has argued, ‘There cannot be well-being but in the combined presence of personal, relational, and collective well-being’.

When understanding becomes too narrow the more likely it becomes contestable. It cannot be seriously contested that in virtually any workplace, the nature of the work experience is a key factor in the worker’s overall well-being. It is important to maintain our awareness and keep an open mind to the combination of factors that may be impacting upon us. Then the challenges and stresses involved in the work, rather than leading to vicarious trauma, compassion fatigue and burnout, instead can lead to personal and professional growth and development.

Reference


Comments

Traci Cimino, Social Worker/Consultant, Canada

Patrick thanks for highlighting the importance and influence of language. Your use of ‘Lack of Support Fatigue’ seems more encompassing, or at least less narrow. There is no inherent assumption on where the "lack" is coming from therefore allows for a more open exploration.
Sujata Jayaprakash, Co-Founder Of Kites Global & Manager Caring for Carers In Residential Homes, India

Thank you Patrick for sharing this article. It is so, so important and crucial before things get critical. In our work with caregivers in India we have been emphasizing on self-care and have started talking about Vicarious Trauma as part of our training and have introduced EQ group therapy for caregivers in homes, a skill that changes everything.

Janey Kelf, Training in Art Therapy, Australia

Yes good article helped me as now Oxygen mask could stand for yoga, fun with friends, a swim a nothing day for rest and relaxation filled with yummy food and nothing that must be done...

Clodagh King, Programme Manager, Carmona Residential Services, Ireland

Great piece- insightful. I am sure that staff working directly with individuals will be happy to have this quite simply recognised and affirmed. Delighted your bloggers block has come undone...

Neil McMillan, Head of Service (Independent Child Protection Consultant), Scotland

Nice piece. I liked the airline metaphor. With staff I often use the lifesaving metaphor for self-care, 'don't jump in to save a life when you can't swim'.

Patrick Tomlinson

Thanks Neil - early in my career our clinical consultant at the time, Barbara Dockar-Drysdale told me when I was wondering if I could survive the extremely testing behavior of the young people - 'sometimes the most important thing you can do is to survive and be there the next morning'. It was good advice and seemed manageable! It was also an empathetic response as I didn't feel that much else was possible.
Why Horses can be so Therapeutic in Work with Traumatized Children and Young People

The first 14 years of my career was in a therapeutic community for boys who were traumatized due to abuse and neglect. The Cotswold Community was situated on a 365 acre farm. I have often wondered how much of the boys’ healing was gained from living on the farm and spending so much time doing activities and being outside.

In more recent years, many research studies have highlighted the benefits of therapies that connect people to the natural world. For example, wilderness therapy, equine therapy and the therapeutic use of pets and animals. As well as these types of activity contributing to the recovery from trauma we also know that they can be generally helpful in reducing stress and improving other health conditions. I believe many of these approaches are what Bruce Perry (2004) has termed ‘biologically respectful’ because they connect people to their genetic predispositions.

I invite people who have particularly interesting and innovative perspectives the opportunity to write a guest blog. This is the first guest blog and I am delighted to introduce Debbie Woolfe and her organization Stable Relationships, which is based in Telford, West Midlands, UK.

Patrick Tomlinson

Stable Relationships is an organisation that has recently been set up to enable more children, young people, staff and carers to have access to emotionally intelligent, therapeutic and training activities involving horses.

All our programmes combine the theories of child development and trauma with the practicalities of equine based experiential learning. Many of our activities are based on the Epona approach (Linda Kohanov, The Tao of Equus, 2001).

Horses are prey animals so their first response is that of fight, flight and freeze. They communicate non-verbally by picking up on the energetic waves of emotion in their herd, in order to stay safe. This makes them hypervigilant and excellent at reading the emotions of anyone they interact with. Our approach is based on the knowledge that we need to be calm in order to build relationships and learn. Horses are most able to complete tasks successfully when the people working with them are able to be emotional leaders. This usually involves the people becoming calm as the first step towards any activity.
Horses respond to their environment and people interacting with them in similar ways to traumatised people, which makes them excellent at helping staff who work with these people.

Through the work with horses, staff are better able to understand the impact they can have and develop new strategies to improve their working practice. For example, we do an activity where a staff member approaches a horse with the goal of it touching them on the back of the hand. The horse is loose in a space. The person has to become aware of their own feelings of excitement, vulnerability and fear within the challenge, and manage these feelings to become calm. They also have to notice tiny movements within the horse, such as a flick of the ear or a swish of the tail. When they see these things they understand how sensitive a horse (and the children/young people they work with) can be. They develop practical strategies for approaching in a way that promotes maximum calm. Self-awareness is a large part of the course and staff have reported it impacting their personal as well as professional lives.

Part of our young person course involves them setting boundaries with horses. As a horse approaches they notice and rate their feelings as it moves. They are taught how to stop a horse coming closer than they want and are given the opportunity of experiencing and regulating their own arousal levels and emotions as it approaches. For young people who have experienced various types of abuse or who struggle to regulate higher levels of emotion, this experience can be highly empowering.

We also take horses out to schools to teach emotional intelligence sessions. Children work through various tasks to help them feel calm, observe and become aware of the messages behind their emotions, and learn how it feels to be trusted and trustworthy. One activity involves leading horses through various obstacles. The horses need to have a high level of trust in the young person to face obstacles, which may feel challenging to the horse. For a young person to achieve the task successfully they need to be calm, take things at the pace of the horse, keep the horse safe, communicate effectively with it and encourage it.
Finally, we offer creative curriculum sessions for young people who may struggle to engage with classroom based types of learning. The outdoor environment with all its noises, smells, space and practical learning opportunities is excellent at engaging young people in learning. Our horses recently helped us teach Macbeth to a group of young people from a special school for children with emotional and behavioural difficulties. After orienteering to find and read parts of the Macbeth story, the horses were painted with Macbeth group symbols, and ridden, once the young people had answered Macbeth quiz questions.

Stable Relationships is in its very early days. However, we have seen the amazing impact our work has. We are lucky enough to regularly see young people work so well with each other and their horse. Often these are young people who are having major difficulties in their relationships due to very challenging behaviour. We are privileged to regularly see young people who won’t walk past a horse, riding one a few weeks later. We are inspired as we see staff and carers who are demoralised and exhausted realising that they are more powerful and effective than they ever imagined. All our horse based work is experiential and due to this, knowledge becomes wisdom at an accelerated rate.

Here are a couple of brief anonymised examples of our experiences,

**Ben**

We have a young person Ben who has been doing our course for 6 weeks now, so he is halfway through. He attends a special school and his referral form said he has autism and depression. When he started he was very withdrawn and the first week he refused to leave the cabin, to even walk past the horses, never mind work with them.

As the weeks have progressed he has become far more confident with the situation and the horses. He has developed a stronger relationship with his carer and is able to ask her for help when he needs it, which was one of his key objectives. During the early weeks the carer did most of the horse based activities and Ben watched, seemingly not too engaged. However, as the weeks have gone on, he has become much more involved. He now takes the lead with all the horse based activities, asks questions, and speaks to everyone involved about his internal processes and views. His carer has reported that he doesn’t seem depressed any more, and he tells her that visiting us is the best part of his week.

During his last session we were working on rating our own stress levels as we worked with quite a large horse (actually the largest we have). The carer rated herself as having higher levels of stress than Ben. At first I thought he may not have been entirely honest but the horses always know! His task involved leading the horse around various obstacles that she hadn’t seen before. She is quite a flighty horse, and was much less willing to go with his carer. The carer was trying to stay calm and talk gently to the horse, encouraging her to move with her. She did go, but was very hesitant and unsure and kept freezing, before continuing on. When Ben had a turn, she went willingly. She tried new obstacles and was completely engaged and attentive to Ben throughout the whole task. He was so calm and focused, and that impacted on the horse. It
demonstrated very clearly that it is a person's internal feelings that have the biggest impact on horses, and people around them. Ben had been truthful about his levels of calm and it had been clearly shown by the horse’s response. For him and his carer, having experienced that level of calm in a potentially challenging situation was an eye opener. We were able to discuss other potentially challenging situations, away from the horses, where Ben now thought it may be more possible to stay calm. He just needed to re-create the feeling that he had just experienced. He could recall the experience he had just had, and recapture the feeling of calm. It was also a big breakthrough in terms of his self-esteem. He is well aware of how far he has come, from not wanting to walk past a horse, to leading around the biggest one at the stables.

Amie

Another example comes from a school we visited last week. We take the horses to work with groups of up to 8 children for a 2 hour emotional intelligence programme. Amie who is 8 years old has had 4 placement moves since June. Her teacher reported that she had very challenging behaviour and showed no fear or concern for others. She worked well with horses and was excellent at spotting the emotions in them. When it came to the end of the session she was hugging her horse and didn’t want to leave it. We gave her some time and she gave the horse a carrot as a good ending. However, it seemed to impact her teacher more. She started to cry because she said she had never seen her show feelings for any other being before. We are used to seeing these reactions but it is always a humbling reminder of the power of the horses, and the differences they are able to make just by being themselves.

Debbie Woolfe

For more information please contact: contact@stable-relationships.com
http://www.stable-relationships.com/

This is a book on Equine Therapy that may be of Interest,

The Listening Heart: The Limbic Path Beyond Office Therapy, http://goo.gl/3WVawx

And an interesting website

LEAP Equine Facilitated Psychotherapy & Learning, http://www.leapequine.com/

References


Comments

Jenny Huston, Qualified Therapeutic Foster Carer and Person Centred Counsellor, England

I have horses and many other furies that over the years of fostering have proven to be a gateway for my children and young people to start their journey of trust again. I feel they can teach/show us so many things and provide a great sense of belonging, responsibility and empathy without any words spoken.

Patrick Tomlinson

Here is a further blog by Debbie on her therapeutic work with children and horses http://www.ukfostering.org.uk/news/why-horsing-around-may-just-help-your-child/

A brief video about Stable Relationships from the UK Channel 5 TV channel, showing horses and children in a school, https://goo.gl/F8xWY4

A Few books recommended by people who read this blog,


Horse as Teacher: The Path to Authenticity, http://goo.gl/5y8dvO

The Children of Raquette Lake: One Summer That Helped Change the Course of Treatment for Autism, http://goo.gl/9S2WB5
A Taxi Driver’s Timely Comment on Brain Plasticity

Since I started writing blogs a few months ago I have realized that there are some things worth writing about that may just be like a mini blog – of which this is one.

I was recently travelling by taxi to give a talk in Sydney on childhood trauma and recovery from it. I’m never certain exactly how I will start off a talk and usually just see whatever occurs at the time. The taxi driver was a man in his mid-20s from Nepal who had been living in Australia for 3-4 years. During the two weeks I was in Australia – I heard some fascinating stories and interesting views of many taxi drivers, from Pakistan, India, Kazakhstan, Iran, Greece and Turkey among others. Occasionally we sat in silence for most of a journey, but generally a conversation ensued.

The Nepalese driver and I were talking about different weather climates. How it could be very hot during Sydney summers, cold but not too cold in the winter. He said that Nepal had a moderate climate, warm most of the year round. I mentioned Ireland, maybe unfairly, where I said they have a few warm sunny days a year and it rains a lot of the time. I had recently been told by an Irish friend that it had been raining every day for 2 months! However, I said people get used to what is normal for them and probably don’t mind so much.

Just before I got out of the car the taxi driver said ‘the human being is like rubber’. An excellent and timely observation on the plasticity of the human brain, which I would soon be talking about - in relation to the potential for recovery from trauma. Possibly, it was also a reflection on how immigrants might adjust to their new environments. It also showed me that just by listening and paying attention, we can be provided with insights and gifts when we least expect them! Maybe those are the best kind of gifts. His comment certainly helped get my talk off to a good start.