

# Developing Skills in Therapeutic Communication in Daily Living with Emotionally Disturbed Children and Young People

Maria L. Ulloa\*

*The University of Reading Pre School, Berkshire*

## *Resumen*

Este artículo muestra cómo desarrollar habilidades para la comunicación terapéutica en las personas que trabajan con niños y jóvenes con perturbaciones emocionales. Este es el marco de trabajo del *Curso de comunicación terapéutica con niños y jóvenes del postgrado en cuidados infantiles terapéuticos de la Universidad de Reading*. Se muestra que las destrezas intuitivas de trabajo con ellos, no son suficientes, debido a que requieren un apoyo terapéutico mayor que otros niños y jóvenes que no están perturbados emocionalmente y por ello precisan que se les provea de buenas experiencias primarias, seguidas de la ayuda para que comprendan, simbolicen y puedan conceptualizar la experiencia; por lo tanto, es necesario desarrollar en las personas que trabajan con ellos, habilidades que van más allá de proveer buenos cuidados básicos.

*Palabras Clave:* Destrezas, Comunicación terapéutica, Perturbación emocional, Experiencia primaria, Comprensión, Simbolización, Conceptualización, Curso, Sostenimiento, Juego.

## *Abstract*

This article shows how to develop skills in therapeutic communication with people who work with emotionally disturbed children and young people. This is the framework of the Therapeutic Communication with Children and Young people Course of the Postgraduate in Therapeutic Child Care at the University of Reading. It is demonstrated that intuitive skills are not enough

---

\* La correspondencia relativa a este artículo debe dirigirla a Maria L. Ulloa, University of Reading Preschool, The University of Reading Pre School, Employees Social Club, No.2 Earley Gate, Whiteknights Road, Reading, Berkshire, RG6 6AU, Correo electrónico: info@universityofreadingpreschool.co.uk

because these children are in need of a greater therapeutic support than those who are not emotionally disturbed; hence, they need to be provided of good primary experiences, followed by the child's realization, symbolization and conceptualization of the experiences. Therefore, the workers need to develop skills far beyond those of providing good basic childcare.

*Keywords:* Skills, Therapeutic communication, Emotionally disturbed, Primary experience, Realization, Symbolization, Conceptualization, Course, Holding environment, Play.

The changing culture of social work with its increasing emphasis on care management is leaving little time for the more intensive or longer-term therapeutic work, which once attracted many field social workers to the job. This does not mean that a sound assessment of a child's needs no longer demands the full range of social work skills. On the contrary, it can be argued that when a child's future may largely hang on a concentrated assessment the skills of an informed and reflective practitioner are needed more than ever. I make the case for this elsewhere (Ulloa and Farnfield 1999). Here it's wanted to pursue the question as to how and where the therapeutic work can take place and argue that the time is ripe for a renewed focus on the potential for therapeutic communication in daily living settings. The need to build on workers' intuitive skills through training in therapeutic communication with children and young people will be considered.

A framework for thinking about therapeutic communication based on a match between a child's normal emotional development and the therapeutic process will be explored. The therapeutic process needs to begin at the point at which normal development towards integration was interrupted, which for many disturbed children was infancy. The first stage of the process is provision of good primary experiences, followed by the child's realization and symbolization of experience, leading in turn to a cognitive conceptualization. This framework is used in the Therapeutic Communication with Children and Young People course of the Postgraduate Diploma/MA in Therapeutic Child Care at the University of Reading. Demonstration of the application of this framework in practice comes from course members' written work.

### *When is childcare therapeutic?*

A senior staff member of a children's home, which I know does some excellent work with individual children and young people, told me in conversation recently that 'of course' they could not do the therapeutic

work which therapeutic communities do. Certainly, the resources available to each are not equivalent, but although resources matter, they are not the whole story. This staff member went on to express her sadness and frustration that her voice was rarely heard when field social workers were making plans for the future of children whom she had got to know well and whose emotional difficulties she had gone some way towards alleviating. She needed support in her underlying recognition that the work she was doing was important and was indeed therapeutic.

Comparable scenarios exist elsewhere. A family centre worker may be involved in productive day to day relationships with children and parents. Foster parents have an intimate knowledge and often a sound understanding of their foster child. Some children's teachers in schools, psychiatric nurses in hospitals and adolescent units, or residential care workers with learning disabled children or young people have similar skills. The expectation common to all these workers, held of them and often also by them, is that they should provide good enough childcare but leave therapeutic work to the *experts*. Such a distinction deserves closer examination.

All children need good enough childcare. This consists of the opportunity to grow up within the containment provided by secure relationships with primary and secondary attachment figures, people who hold the child in mind, and who manage a satisfactory balance between meeting the child's dependency needs and his or her needs for independence and creativity. Where this care has been lacking, whether for all or some of the time, or where a particular trauma or series of traumas has rendered such care inadequate or put particular strains on it, then emotional difficulties are the inevitable outcome.

Workers involved with children with emotional difficulties are not starting from the same point as those caring for children who are not damaged. It may seem an obvious statement but its importance lies in the implication that provision of good enough childcare will *not* be sufficient. There is repair work to be done. Moreover, the therapeutic task is relevant to every aspect of a child's experience. Although some therapeutic interventions (such as family therapy, play therapy, psychotherapy) may be formally structured to occur at certain times and places, and by people with specific skills, there is also vital therapeutic work to be done in the course of everyday living. Working alongside a child or family in the prolonged experience of daily life presents its own opportunities for therapeutic communication. Some of these may be planned interventions but much work is spontaneous and *opportunity-led*. This therapeutic work can take place in any setting – local authority children's home, foster home, family centre – provided certain conditions are met, and it is not the exclusive preserve of *therapeutic*

*communities*, although the model which they provide may be valuable. Thus, therapeutic childcare for emotionally damaged children requires the worker to have skills far beyond those of providing good basic childcare.

### ***Intuition is not enough***

Where do the therapeutic worker's skills come from? Some people have had a basic professional training, although there are many with little or no training of any sort. Such training as exists rarely addresses the skills needed for the therapeutic task. Occasionally in-house training as well as *working alongside* enables the transmission of some skills. Workers rely on a more or less informed intuition. Their intuitive skill arises in part from their own past emotional experiences, which provide a basis for empathy and an ability to pick up subliminal cues, and from thoughtful concern for the child. Here are two examples, one from a residential children's home, and the other from a family centre:

In nearly all her conversations with staff, J, a 15-year-old girl claimed that another girl P, a year younger, was receiving preferential treatment. I observed J break an egg. When I asked her to clean it up, she replied that she had not broken it. On being asked again to clean up the mess she retorted, *It wasn't me, it was her*. Instead of correcting her I asked, *Do you always get blamed for the things that she does`?* She replied, *Yeah, no one ever believes me. She gets away with everything*. From the ensuing conversation, I realized that J was actually referring to her younger sister, with whom she had a poor relationship. Again intuitively, I asked J who out of the resident group of young people most reminded her of her sister, and it was the girl she had complained about. Following this incident J referred to P less and developed a bond with her. A mother recently became very frustrated and angry when her child refused to eat his dinner. The child became quiet and cried silently, but the mother continued to nag angrily. The worker resisted her initial thoughts of reassuring the parent that all really was well and giving her a few encouraging ideas for making meal times more pleasant. Instead, she asked what mealtimes were like when she was a child. The mother described a similar scenario to the one that had just taken place, and talked about the poverty her family had struggled with, the anger of her father and the guilt that she felt in this. She did not seem to make any connection with the scene that had just taken place in the present. The worker talked about what it must have felt like for that child, fearful to eat a scarce resource and yet fearful not to eat and evoke her father's anger. As the mother got in touch with her own childhood self and

remembered (and felt), these feelings she was able to work more freely on a resolution to the mealtime difficulty .

The therapeutic importance of such communications can be undervalued and the chance to build on them lost unless both individual worker and the staff team as a whole are able to locate such interventions within a theoretical framework, which helps them understand what is happening, and offers some guidance about what to do next. Hence, the need for training, not only for those working directly with children, but also for managers and trainers who have a role in enabling others to do this work.

*Locating a course in therapeutic communication within a training programme in therapeutic child care*

A structure for training, which matches the demands of the difficult and intricate work of therapeutic childcare, is explored by Ward (1995). Here it is focused on one aspect of this training, the development of skills in therapeutic communication. An account of the working method will underline the importance of integrating this course into the structure of the programme as a whole.

The course in Therapeutic Communication with Children and Young People consists of thirty one-and-a-quarter-hour sessions over one year, and uses experiential exercises, role-plays, and practical exercises in communication in order to develop understanding and skills. These exercises are complemented by seminar discussion of reading (of a journal article or book chapter) given the previous week, which provides the theoretical base as well as discussion of practice. Further links to practice come from course members' presentation and discussion of child observations and of their work with children and young people.

The quality of therapeutic communication with children depends ultimately on the worker's use of self, a blend of the personal and the professional. Part of training involves working at this, developing and deepening self knowledge, as Ward (1995, p. 203) explains. The use of experiential exercises in the therapeutic communication course gives some prior warning of the feelings which may be aroused in work with a child, as well as giving some indication of the power of that experience to a child. Experiential work helps course members to understand their counter-transference feelings, distinguishing those that arise out of their own previous experience from those which are a more direct transference from the child. However, there is not always sufficient opportunity within the time boundaries of the course for individual painful feelings to be worked with. The holding environment

of the whole programme becomes crucial. The containment offered by a separate experiential group led by a facilitator later in the day, and the closing meeting with the whole staff team present, make it possible to think about some initially unmanageable feelings.

For example, in a 'good memories' relaxation exercise (Oaklander 1978) students were asked to feel warmed by the sun. Far from finding it relaxing one European student recalled horrendous memories of the sun burning her as a refugee child in flight and an African student also had memories of being burned. For some others even the recall of good memories unleashed strong feelings. The experiential group, and later the closing meeting, gave space for these feelings to be further expressed and explored. The staff meeting at the end of the day enabled the whole staff team to deepen their understanding of the different feelings involved. While it may be the case that the choice of this specific exercise was inappropriately ethnocentric, it will always happen that people experience things differently and we need to work with those feelings. The holding environment of the whole programme enables such reflection.

### *The match between emotional development and therapeutic process - a basis for course design*

The progression of the course on therapeutic communication is designed to reflect both the stages of a child's emotional development and the related process of therapeutic work. Bowlby's (1984) attachment theory and exciting recent developments in research in this area (Greenberg et al. 1990), are clarifying the connections between impaired attachments in infancy and later disturbance. Winnicott (1965) earlier described the evolution of the gradual maturational processes of separating out of mother and baby by which the child would achieve integration, and the need to understand these processes and the point at which they were interrupted, since this determines the child's current survival mechanism and suggests the appropriate therapeutic intervention. Dockar-Drysdale, who applied Winnicott's ideas in residential therapeutic work with children (1968, 1990), usefully summarizes:

We are thinking in terms of a series of processes which must be gone through in order to reach integration. These are experience, realization, symbolization and conceptualization. By this I mean that a child may have a good experience provided by his therapist, but this will be of no value to him until he is able, eventually, to realize it; that is to say, to feel that this good thing has really happened to him. Then he must find a way of storing the good

thing inside him, which he does by means of symbolizing the experience. Last in the series of processes comes conceptualization, which is understanding intellectually what has happened to him in the course of the experience and being able to think this in words (...) It is not enough to give emotionally deprived children good experience, we must also help them to keep the good things inside them, or they will lose them once more. (Dockar-Drysdale, 1990, p.98-9)

This account of the sequence of processes involved in therapeutic work provides a useful model, which the three terms of the therapeutic communication course broadly match. First, some general points:

The choice of a specific approach to therapeutic communication with a particular child or young person needs to be based in an assessment of their emotional and cognitive development. Whatever the child's emotional stage we need to make the stage related provision in ways that respect chronological age and individuality. We need also to work with thought for the child's family and culture, with attention to anti-racist and anti-discriminatory practice. The latter is particularly important when the diverse nature of workers' previous education or training may mean that this has not been addressed before.

### *The unintegrated child and the need for primary experience*

*First, as Anna Freud says, build the house; first, as Klein says, introject the good breast; first, as Bion says, you have to have an adequate container; first, as Bowlby says, have a secure base.*  
Álvarez (1992 p. 117).

The first and largest part of the course focuses on how to enable children to have and hold on to that crucial good primary experience. This is the starting point for many emotionally damaged children, certainly for the majority of children in residential care whose deprivation started in infancy. Some workers intuitively provide some of this primary experience but need to work within a framework of support from their work place if they are to get very far. Unless they already work within a therapeutic community, they are often surprised by the emphasis on primary provision on the course. They can be anxious about managing children's regressive behavior and benefit from understanding what it is that they are doing.

The course uses experiential exercises that demonstrate the powerful feelings of primary experience, practical exercises that help in planning provision, and specific exercises in communication. The theoretical content

of the course is outlined in the sections that follow, with application in practice illustrated by course members' work.

The unintegrated child lacks a sense of a self separate from others. There is no sense of what is *me* and *not me*. The child does not feel not held within its skin but experiences *falling to pieces* or *falling forever* (Winnicott 1965). Feelings cannot be held onto and thought about but have to be got rid of onto other people, often in massive blame and projective anger, or sometimes in a delinquent merger with other children. Violent panics and disruption are the *hallmark of unintegration* (Dockar-Drysdale, 1990, p. 137). Without a sense of self and agency the child cannot take responsibility for his or her own actions, often literally not able to remember, even moments later, for example, deliberately breaking the window. Even good experiences and feelings cannot be held onto; as for example in the child who has appeared to enjoy a day by the sea and looking back that evening can only say *the food was yuk*.

Such children's damage goes back to infancy. There is often a history of insecure attachment, with children developing the defenses of severe forms of avoidant or ambivalent/resistant attachment or more extreme disorganized/dissociative attachment. The latter has a parallel in Dockar-Drysdale's notion of the completely unintegrated *frozen* child. *Archipelago* children have islets of integration, holding on to some good experiences. *False-self* children have an outer shell, which protects the frightened child within. Dockar-Drysdale's (1990) Need Assessment, with some updating, is a particularly useful tool in considering the extent of a child's integration.

To understand what unintegrated children have lacked and still need, it helps to consider the experiences of children in the course of normal development. Winnicott's notion of the holding environment and maternal preoccupation has echoes in Bion's reverie or containment (Copley and Forryan 1987). Recent research into infancy has elaborated our thinking about *motherese* (Bruner 1983) and the mother's attunement to her baby (Stern 1985, Brazelton and Cramer 1991). I use the word mother while recognizing that mothering does not necessarily come from the biological mother, or even from women; mothering can also be done by men. The common thread is the notion of the mother's attentiveness to her child's communication and her ability to bear and to think about this, holding on to all the baby's feelings without feeling overwhelmed, and giving them back to her infant in a more manageable form. This enables the infant to take in more good feelings than bad ones, becoming able to hold on to them and in time becoming a container in turn.



A further aspect of mothering involves the ability to notice and respond not only when the child is vociferously angry or distressed but also when he or she is depressed or mentally distanced. The good enough mother is able to reach out to the infant, carefully managing the timing and intensity of her approach, to bring the child back into contact with her and through her to the world. Alvarez (1992) applies this notion of reaching out in psychotherapy with borderline children. It is also applicable to therapeutic communication in daily living with damaged and abused children.

### *The provision of primary experience*

We can use understanding of the *normal* processes of parenting when thinking about therapeutic communication with unintegrated children. Fundamental is the provision of the *holding environment*, a safe space physically and emotionally within which the child can start to grow. Alvarez describes it as the child needing to forget before being able to start to remember; *while this non-abusing world is built up, the therapist may have to respect the child's need to keep out both abuse and the past* (Alvarez 1992, p. 162). Sometimes there is an added dimension to the holding environment; in family centre work, for example, the child may also be supported indirectly through the holding environment provided for the parent.

As the mother meets her infant's physical and sensory needs, for warmth, comfort, sensual contact, and food, through this first relationship, so we can make appropriate parallels in primary provision in child care. A child needs sensitive and responsive care, with attention to reliability and continuity in managing the events of daily life, from waking and dressing, to play and school or work, food and mealtimes, travel and other in-between times, bath and bed-times. Provision of good sensual experiences restore a child's blunted senses. An important part of this work involves providing complete experiences with attention to the child's experience of their beginnings and endings. The whole task is too great for a single worker, although her contribution may be significant; provision for an individual child must be managed by the staff team as a whole. The following example shows how this task can be done.

Eight-year-old Wayne was a stocky unattractive boy who was difficult to warm to. He was placed in a local authority children's home after his foster placement, his fourteenth move, had broken down after his violent sexual assault on a four-year-old. He had previously been living with his father who had a history of violence, although he had spent his early years with his mother, mainly in different women's refuges. He idolized his father and said he wanted to be with him (father was therefore given regular

contact). On his arrival in the children's home Wayne stood in the doorway and urinated at the staff there to greet him. He spat, kicked, head-butted and screamed his way through the day, interspersed with idyllic behavior and profuse apologies to those around whom he had hurt. His mood swings were extreme and, as one worker put it, 'When he goes he's quite frightening -like that child in *The Exorcist*'.

While initially fearful for the safety of other children, staff became excited at the prospect of working with such open disturbance in a structured, shared and open way, involving a team approach as well as individual supervisions. We decided that come what may we would try to hang on to Wayne. We saw him as an *archipelago* child and understood that he too found his panic states very frightening. We gave him a clear message that aggression towards others was not acceptable and that we would stop him, by holding him physically if necessary. When he panicked we made sure we never left him alone, held him if necessary, and communicated with him throughout.

We felt that we needed to do things for Wayne as he showed no control over everyday matters. He would run a bath and deliberately let it overflow; he would lose his toothbrush every day and not clean his teeth when a new one was produced; he would pour half a bottle of ketchup over his dinner and then slurp his food up with his fingers. Staff started to run his bath for him, clean his teeth for him and ask him if he had wiped his bottom when he had been to the toilet, giving him undivided attention. Someone was with him during all his waking hours, doing things with him and for him. His whole day was organized for him, trying to make things uncompetitive and achievable, encouraging his interest in art, swimming and growing things. We bought boxing gloves and a punch bag in the hope that he could channel his aggression. We gave him a Wendy house, sleeping bag and tent so that he could hide himself away in his bedroom. We sat beside him on the floor (due to his destroying all his furniture) reading him bedside stories and singing lullabies at bedtime.

Wayne is now inwardly and outwardly a much happier child. His violent outbursts have diminished greatly. His replacement furniture in his room remains undamaged and he is starting to put down roots. His knowledge and interest in growing things was a way of helping him relate to other children who had until then seen him as a *nut case*. His healthy response to one of the staff the other night was *I'm not going to let her wind me up you know* and he promptly had a bath and came out managing himself well.

A team approach made possible the good experiences that Wayne received. He was able to hold on to enough good feelings to be able to start to think.

### *From annihilation to hope*

Primary experience gives a basis for the formation of attachments in which the worker becomes the mirror for the child's developing self. Although a potential attachment figure or figures may be available to the child from the outset, these also need the support of a holding environment that can manage the potentially overwhelming feelings arising from working with damaged children. Angry and violent children out of touch with the source of their emotions can be very frightening to work with, as the previous example indicates. The worker's task, so potently described by Dockar-Drysdale, is to experience repeated annihilations by the child, not simply to empathize with the child's pain but to feel it personally, and to survive with their concern for the child undiminished. Out of this come the beginnings of hope within the child that he or she too may have a future. That this is possible is demonstrated here.

Femi is a thirteen-year-old black girl. She was taken from West Africa to Britain when she was about nine. It was clear that she had suffered a lot. In Africa, she was never told who her parents were or who she was. She was then uprooted to an alien culture where for two years she relied solely on a family she did not know in a situation she was not clear about, where she was treated as a maid and sexually abused. On being found and taken into care, she was moved round a number of residential units and foster placements, all of which broke down, mainly because of her behavior. At one stage, she was moved ten times in two months, causing her increasing distress and a sense of hopelessness. She was referred to our therapeutic unit, which has a black African woman manager, and staff who are mainly black and female from a wide range of cultures. It was agreed that she should move into the unit in a planned way so that a structure for her daily care was in place and everyone involved would be clear on all the details.

On our first meeting, I was left with the feeling of having met a toddler who giggled inappropriately, and I wondered if she could understand what I said. Soon after her arrival, Femi fought with another resident and broke all the windows and some furniture in her bedroom, hurt the staff on duty, and had to be restrained for about two hours before she finally collapsed and fell asleep. The next morning she refused to take responsibility for the damage she had caused, but later asked *If it is true I did this can you help me*

*to remember such events* . She also said, *Someone who is not me takes over when I get angry and I am scared* .

Femi frequently ran away, sometimes being brought back by the police. Each time she would beg me to end her placement saying *You are the manager, tell A (the social worker) that Femi is a horrible girl and we cannot cope with her behavior* . I refused and told her we could cope. Once she lost her temper and broke the glass in the door and generally caused such extensive damage that the police were called. The police did not want to return her to us as she was making allegations. They wanted to press charges for criminal damage, which I refused to do, telling them she was not a criminal, and I insisted that she come back. She returned, only to attack me for having agreed not to end her placement. It was then I decided that we would not call the police again and that we quickly needed to come up with some kind of safety net for her to feel held by us.

Femi clearly did not like herself. She asked staff to buy her pornographic material. She was very depressed and wanted to remain detached from everyone. She attempted suicide by drinking cleaning fluid and some paracetamol. Her level of distress was touching everyone within the unit. As a team, we felt that she really needed our commitment, and that ending her placement would only make her situation worse. Her daily living experience had to be structured through activities and individual attention. The drama therapist built some trust through Femi's interest in singing and dancing, and art therapy was a way for her to talk about her life in Africa. We tried to encourage Femi's attachment to her keyworker, whose task was to become maternally preoccupied with her. Femi found it difficult to trust this attention, and remained aggressive, depressed and anxious, keeping everyone at a distance. We had to understand her level of distress and not reject her.

The staff group felt that Femi was 'workable' but the need for her to be restrained for long periods caused much anxiety and stress. No one spoke her language and none of us knew much about her religion or culture. It left me feeling that although I am black African I did not understand all that was going on for her. Femi was also verbalizing her internal racism towards staff. She was finally faced with all these *black mothers* whom she could not make use of. This made her very angry with us, and she did not know how to respond except by lashing out. She said to me one day that she wished she had never been born, and that I was the main cause of her problems because I would not reject her like everyone else would.

Femi is still with us six months later but what a struggle it has been for the team and what powerful feelings she has evoked in us. In my work with Femi I became involved with her, passing through a phase in which I was vulnerable as the mother is. I remember feeling greatly concerned when she first ran away, and crying when phoned at midnight to be told she had not returned. I believe that Femi aroused some feelings, which touched me on a personal level, so that I was trying to create a personal holding environment. In attempting the *mothering* of Femi, I found myself struggling with lots of issues and my ambivalence was shared by the team. I was left with Winnicott's idea of maternal preoccupation and Femi needing this level of attention.

Femi no longer runs away and her outbursts are minimal. She has stopped asking me to move her and has finally unpacked her things.

### *Localizing regression*

This point of hope is often when regression occurs. The child starts to trust a little and seeks a way for some basic infantile needs to be met. Dockar-Drysdale (1968) describes how this can be managed whilst maintaining the child's identity. In a residential setting it is rarely appropriate to allow a child to regress completely. Localizing a child's regression, to a particular time and situation agreed with the child, and with a person chosen by the child, preserves the child's ability to maintain age-appropriate functioning elsewhere (and is comparable to what may happen in a *therapeutic hour*). [This kind of regression under the control of the child is very different from forced regression, better described as abuse.] Management of a localized regression or *individual provision* needs the careful support of the whole staff team (Lucas, 1992). This was the case in the following account by Lucas, a therapeutic worker at a residential therapeutic school for younger children set up by Dockar-Drysdale, where this work is well understood.

Sandra came to the School a year ago. She is now nine years old. She has been with foster parents since the discovery that she and her younger sister had been physically neglected by their alcoholic mother and severely sexually abused by their father and a good many of his friends, with her mother's consent, at a very early age. Her contact with me started in various group situations within the school, mainly at getting up and going to bed times, in play activities, during outings and through a regular lunch-time bath.

Relatively soon, Sandra started developing a dependency relationship with me, which the staff team formally acknowledged,

allowing us a weekly one-to-one half-hour session, called a *special thing*. Consulting Sandra, I decided to use Sunday lunch-time for our *special thing*, because I hoped that feeding Sandra might provide a useful regressive experience. As a location I chose, at Sandra's wish, a play flat (formerly a staff flat), containing a bathroom plus toilet, a sand and water area that used to be the kitchen, and a big play area with a settee, lots of bean bags and plenty of toys. The flat is within the main building but on the periphery, providing a safe place relatively free from impingement from other children.

According to the School's practice of providing, if appropriate, a drink and some food for a child's *individual provision*, Sandra chose a can of Coke, chocolate ice cream and a bag of crisps. The *special thing* being set up in this way, a pattern soon emerged. Sandra brings her bed cover with her, takes some of her clothes off and snuggles under her cover on the settee in the play area. Then she asks me whether she can be my baby, and how old she is. Usually she wants to be a very small baby, no more than a few months old. Then she likes me to feed her lunch, to which after a few sessions I added real baby food at her request, which she eats like a really messy baby.

Often Sandra interrupts the feeding by hiding under her covers. I then have to pretend to have lost her and cry bitterly, until she moves so that I can *find* her again. When we are re-united, we both are relieved and happy. When the feeding is over we often play hide and seek, which she enjoys very much, even though we usually know where the other is hiding.

When her time is up, Sandra usually does not find it difficult to accept the end of her *special thing* and to join the other children.

Sandra and her worker used a special playroom but simpler provision can also be made to help a child *go back* emotionally and fill in the gaps of missed primary experience. Sometimes a child asks for special food at bedtime which she will receive from the worker with whom she is building a relationship. In the following illustration from a therapeutic community, a boy requested a special bed.

One boy I worked with was Zak, thirteen years old, untidy and easily led into delinquency because he lacked the ego strength to decide for himself to stay out of other people's trouble. Zak's clothes, possessions and room were always in turmoil. After many months of looking after Zak he suddenly asked me if he could make

his bed into a boat I had no real idea why this might be important for Zak other than as some sort of totally enclosing safe space for him so I said I thought that would be a great idea.

We proceeded to construct a boat shape which would fit over his bed, using two sheets of hardboard bent to form a prow at one end and with two pieces of 2x2 timber erected a mast at either end. Zak seemed pleased with our efforts. A few days later Zak called me shyly but excitedly into his bedroom to look. He had attached a long piece of string from the top of each mast running the whole length of his boat and over the string, he had draped a blanket which now fell on either side of the bed like a tent. He was clearly pleased with it so I said, *That looks brilliant Zak. You'll be safe in there.*

It was not necessary to know the full meaning of the boat for Zak but it was good enough to know that it meant something helpful. Through discussion with the consultant it became clear that the boat represented a secure container for Zak's *stormy sea* which was evident from his chaotic room and possibly his life as well. I often thought of how his boat looked like one of those self-righting life-rafts, totally enclosed. I could speculate how much the enclosed boat represented some kind of womb-like structure, warm, dark and safe.

Zak's boat was not a game. It was an important structure, which was not taken apart when the bed was changed, nor was it ridiculed by anyone. Other children had beds built as nests, houses or castles, high up or at floor level, each according to the child's specifications. The culture was such that Zak felt able to ask for something which I suspect he would have been unable to in other places for fear of ridicule or because of a lack of understanding of the emotional importance to him of the provision of a boat. Zak continued to sleep in the boat for many months until he decided himself that he no longer wanted the tent on top. He slept in his open-topped boat for many more months after that. Zak may have got the idea for a boat from family naval connections but it was not important to know this; what mattered was to know how to build it and that it needed to be built.

Zak's boat can be understood as a symbolic equation, in which the symbolic provision becomes the real experience. Zak's worker describes how another child, Robert, had been found concealing in his bedroom six yoghourts that he had taken from the fridge. Although taking food without asking was not met with approval by the rest of the people living in the house, it was

decided to make it possible for Robert to have something that he appeared to need, but in a way defined in terms of appropriate time and place. Robert received a pot of black cherry yoghurt as his special provision five times a week for over a year. He *saved all his yoghurt pots and soon had a stack several feet high, a physical statement of what he had now stored up inside him in emotional and well as nutritional provision*. He had been helped not only to have but also to hold onto that crucial primary experience.

### *Symbolization*

Symbolization, in Dockar-Drysdale's sequence, follows the child's good primary experience and his or her realization that this good thing has really happened. The child uses symbolization as a way of storing the good experience inside him or herself. Early forms are symbolic equations, as we have seen, in which the symbol is also the experience. Symbolic communication, in which a child uses symbols to represent something *else*, is a developmentally later stage, although even some profoundly unintegrated children have pockets of integration and can make use of symbolization earlier in the therapeutic process.

As the child's integration increases and a sense of a separate self develops, (whether the child has arrived at this point though a therapeutic primary experience or because the interruption to their good enough experience only occurred here) painful feelings about neglect and abuse, separation and loss, often surface. Play in Winnicott's (1971) *transitional space* between child and parent/worker, another version of the holding environment, became a way of dealing with these feelings. The use in play of symbolization which is not initially interpreted back to the child but worked with within the metaphor helps give the child enough distance to think about some painful experiences.

There is a widespread interest among childcare workers in developing skills in play therapy, in which play becomes the medium for symbolic communication. The second term of the therapeutic communication course explores therapeutic play and play therapy, and considers related forms of symbolic communication, sometimes more acceptable to adolescents, such as art and drama therapies, books and story telling.

Methods of learning include exercises in symbolic communication, some directly drawing on personal memories and feelings, some a practical application of techniques. They have proved productive, and sometimes painful. They have included Winnicott's squiggle game, Oaklander's Rosebush exercise and other drawing exercises; Make a World sand play, the Child's Game, and related exercises in reflective listening. Sometimes



play materials have been used to represent past experiences of separation and loss, or powerlessness.

In one workshop, course members used junk materials to create a symbolic representation of their work situation where they were undertaking a project in managing change. This enabled more understanding of what it was they were dealing with and their own feelings about what was happening, but also enabled *other* members of the group to think about each project, with the resulting reflective discussion deepening understanding. For example, one senior worker's struggle to contain a difficult group of young people and his feeling of isolation and lack of support was reflected in his creation of a boat which could be split in two. The manager in his bed of prickly leaves plus a huge prow of management committees and consultants could be cast adrift, leaving himself and other workers on the bridge trying to haul in a net full of young people drowning in the sea!

### *Symbolic communication through play*

The following example of practice comes from the M.A. dissertation of a therapeutic worker in a residential therapeutic school, who worked with the symbolic communications of an eight-year-old girl as they occurred in spontaneous play in daily life.

Among Sarah's main emotional preoccupations were her feelings about a mother figure and her need to belong. Her anxieties and needs in this area were so great that she was driven to play make-believe games dealing with this theme almost constantly, day in and day out. Basically Sarah had two games that dealt with this theme, which she could play in a number of variations; one was a dog/puppy game, the other was, not surprisingly, a mother and baby/child game. For months Sarah spent a great deal of time pretending to be a puppy or a dog. She had two basic variations of this game which she would play again and again.

In the first variation she would, for example, initiate a game by whispering to me, *I am your puppy. You are the Mummy dog. Carry me like a puppy.* Following these instructions, we would then play being dogs with me looking after her. She preferred to play this game with me, but if I were not available, she would also play it with other workers. In the second variation, Sarah played being a puppy who is given to somebody, again mainly and preferably to me, as a present. If we were in her dormitory, for example, she would wrap herself in a blanket and lie on the floor or in the washing basket. I then had to uncover her and pretend to be overjoyed at finding a little puppy there, while she would yelp in a rather endearing and helpless way. Often Sarah preceded these actions by telling me, *Pretend you are a little girl and your Mum*

*gives you a puppy as a present (...)* In this variation the emphasis was on the fact that she was given to me as a present and from then on belonged to me. On most occasions the game therefore stopped once I had unwrapped *my present* and had joyfully accepted her as my puppy.

What became apparent in these games is that Sarah wanted to experience being a baby (puppy) belonging to somebody who would be pleased to have her and to look after her. The fact that she wanted to play these games so often indicates that her need for this experience was great, and indeed almost desperate. Considering that her mother had actually found it difficult to feel pleasure at Sarah's birth and to be emotionally available to Sarah, it is not difficult to understand that Sarah felt this need. I would argue that Sarah unconsciously used these games to work through and make up for the loss that she had experienced in this area.

However, the question remains why Sarah so often chose to play out this theme as a dog rather than as a human being. M. and M. Rustin point out that *animals –real and imaginary– are used in many children's actual lives as projections of aspects of themselves and some of their central feelings* (Rustin 1987, p.251). In pretending to be a puppy Sarah did exactly this. She projected her need to belong and be cherished and looked after onto the figure of a puppy. By playing at being this puppy herself, she could take part in what happened to the puppy in the game. But at the same time, by projecting her needs into a *puppy* she could, to a certain extent, distance herself from the feelings of loss that accompanied her need to play these games. Moreover, spending so much time being a dog also gave Sarah a chance to get away from the anxieties and painful feelings that human interaction created for Sarah. I would argue that the relatively simple life of a dog, such as she had watched in her beloved dog at home, had a certain appeal for Sarah and that she found relief from the anxieties of her internal world in playing at being a puppy.

However, it was not always the case that Sarah's puppy games depicted harmonious and positive aspects of life. Occasionally she used them to play out more threatening themes. Once, for example, Sarah played that she was a puppy and I was the mummy dog. I had to pretend that I thought that she was a murderer and ran away from her not realizing she was my puppy. In this short game Sarah expressed symbolically the dilemma that she has faced since her birth; for her mother Sarah was not just a little baby –the puppy in the game– but somebody who threatened the life that she had established with her first born child –the murderer in the game. Therefore Sarah's mother *ran away*, into depression, thus being unable to attend fully to her baby's need, just as I had to run away from her in the game not realizing that she was my puppy.

By playing out (...) painful feelings of abandonment, rejection and loss (...) in a make-believe game Sarah had found the possibility of expressing them and coping with them without being overwhelmed by them, or indeed without becoming conscious of them (...) She also coped with them by projecting them onto me, so that I felt and contained them for her. Lucas (1993, pp. 22-27)

This therapeutic communication through play with Sarah took place, not in special play therapy sessions, but in the normal course of the events of daily life. It was helped by the staff team's recognition that this work was important and needed support.

### *Symbolic communication through fairy tales and stories*

A similar opportunity for therapeutic communication presented itself through Sarah's fascination with certain fairy tales and stories. For example, she loved the stories of Peter Pan and The Little Mermaid *which seemed to express symbolically some of her phantasies and emotional preoccupations and dilemmas* (Lucas, 1993, p. 62). Sarah wanted to hear these stories again and again; she would enact scenes or pretend to be one of the characters, and would ask numerous questions.

Workers in many settings tell children stories at bed times and other times provide opportunities for children to look at and read books, or watch television and video. By becoming aware of the significance of the child's choice of story and working with the communication, which this understanding makes possible, much spontaneous therapeutic work can take place.

### *Conceptualization*

These other processes, realization and symbolization, provide the essential stepping stones to what, after all, conceptualization really is, an economic method of storing experience and at the same time establishing the means of communicating experience. (...) Conceptualization is only of value if it is retrospective-ideas must be the sequel to experience. Dockar-Drysdale (1990, p. 99)

The final stage of conceptualization of experience is given expression in the course's exploration in the third term of more focused and sometimes more directive approaches, in which the child or young person is helped to think in a concrete way about past and present experiences, and to consider the future. The child needs to be able to understand intellectually what has

happened and to be able to put this into words. Since part of this means thinking about painful experience as well as good experience, it can only happen usefully after a child has had enough good primary experience to sustain him or her, then symbolization of this good experience, followed by working through painful experience in symbolic ways.

Consideration of work with the child and his or her family, whilst never unimportant, becomes crucial at this stage, whether or not the child is actually returning to live with family (including adoptive or foster family) or is a young person preparing for independent living or themselves has become a parent. A systems approach helps in thinking about the familial, social and cultural context of therapeutic work with children, with concern for anti-racist and anti-discriminatory practice.

Conceptualization may occur, as symbolic communication is increasingly interpreted to the child rather than remaining within the metaphor. Another approach to conceptualization takes the form of counseling for young people. Both these are explored on the course. Play based work (using Clare Winnicott's (1968) notion of a *third thing* to facilitate communication between child and worker) remains helpful to younger children, and some older ones too. Many social workers have skills in *direct work with children* (and there is abundant literature, e.g. Jewett, 1984; Owen and Curtis, 1988; Redgrave, 1987) but they need understanding of the *process* of development which could guide their use. The course examines some of these tools for conceptualization, such as genograms, ecomaps, life story work, card and board games such as *The Needs Game* or *Barnados, All About Me*. As before, experiential and practical exercises are used, and even experienced workers continue to be surprised at the power of these exercises.

Returning to the earlier case study of Wayne, primary experience was followed by his being helped to use symbolic communication to think about and focus his anger. Only then was it decided *to start some life work with him so that he can have some order and clarity of his life down on paper*. This was an appropriate time to conceptualize his experience. The workers in the children's home who had followed his progress so far were in a good position to judge when the time was right and to carry out this work.

The work of conceptualization, that is of thinking and communicating about the reality of past experiences, often involves painful loss issues. This is shown in the following example from the same children's home.

Marie had spent her first two years with her mother in Africa, who then left her in the care of the extended family for two years before bringing her to Britain. She came into care at the age of

eleven, following neglect and abuse. Her mother became ill with Aids but was insistent that Marie should not know, returning alone to Africa where she died. Marie was told of her mother's death three weeks after the event by her social worker who herself had just been told. Marie became withdrawn, and her confusion and anger were expressed in violent attacks on her carers. She asked her social worker what her mother had died of and was given details of her illness. A specialist was brought in to talk to Marie about HIV and Aids and to allay myths and ghosts around her feeling that she too had caught the disease or was responsible for her mother dying. Frequent visits to a family centre with a soft play area where she could punch and kick out as much as she wanted helped a little. The fact that Marie had no opportunity to say goodbye to her mother or even know where she was buried only increased her desperation. Efforts were made to gain finances to fly her to Africa, but so far in vain. We then obtained permission from the Housing Department to enter her mother's former flat, We took a wreath and Marie made a shrine around the fire place; for the first time she was really able to cry and commence dealing with her emotions. Marie and a worker went to the flat every day for three weeks, where identity and loss work was carried out. She felt in touch with her Mother there and smelled and caressed the surroundings lovingly. We renewed the flowers and lit a candle every day in the flat and cried with her. She became dependent and regressed and this was expected and worked with. The fact that she had lived in the unit for a number of years helped her make attachments again with a specific member of staff. She is still working things through with this worker and attending a loss group at the hospital where her mother had been treated. She is beginning to look at life in a more positive way and managing to cope each day without resorting to violence. Much work is still to be done but grasping at limited available opportunities and working with recognizing and reflecting back to Marie her feelings has certainly helped. We shall continue to strive to finance her visit to Africa as we view it of paramount importance that she has this opportunity to conceptualize her experiences.

This complicated piece of work contains elements of provision of primary experience and also of symbolization at appropriate moments. Its focus, however, is on conceptualization, that is, on communication with Marie about what had happened and how she feels about it. This work was possible because the staff team understood what it was that they were doing, why it was important, and when it was appropriate to do so. The painful feelings which were aroused for workers were managed within the

holding environment provided by a sensitive and supportive manager. She writes passionately,

Realistically there will not be a trouble-free future for youngsters leaving the care system that have not been worked with over separation issues. Penal and mental institutions are full of such figures and it is about time recognition was given to the importance of such work.

### *Conclusion*

I have sought to show that there are numerous and important opportunities for therapeutic communication with children and young people occurring in the events of daily life. While the worker's intuition may enable significant communication, informed intuition has a much better chance of locating the communication within a framework of understanding of the whole therapeutic process. This understanding in turn helps the therapeutic worker to decide how to help the child further. Because daily life is messy and complicated, with plenty of scope for disruption and interruption, and a guarantee that difficult and painful feelings will be involved, the worker needs to work within the active support of a setting, which provides a holding environment for workers as well as for children.

It has been described how the course in Therapeutic Communication with Children and Young People provides a theoretical framework for therapeutic communication and builds on workers' intuitive skills. The process of therapeutic work, from primary experience, to symbolization and conceptualization, as the child struggles towards some degree of integration, is matched in the course structure. The location of the course within the whole program, provides the holding environment which enables workers to engage with the exciting and exacting task of helping children find themselves and live with what they find.

I should like to thank the following course members for permission to use their work: Margarete Lucas, Michele Alfred, Nyasha Gwatidzo, Simon Peacock, Viv Dacre, Matt Vince.

## *References*

- Álvarez, A. (1992). *Live Company: Psychoanalytic Psychotherapy with Autistic, Borderline, Deprived and Abused Children*. London: Routledge.
- Bowlby, J. (1984). *Attachment and Separation*. London: Penguin.
- Brazelton, T. B. and Cramer, B. (1991). *The Earliest Relationship*. London: Karnac.
- Bruner, J. (1983). *Child's Talk*. Oxford: Oxford University Press.
- Copley, B and Forryan, B. (1987). *Therapeutic Work with Children and Young People*. London: Robert Royce.
- Dockar-Drysdale, B. (1968). *Therapy in Child Care*. London: Longman.
- Dockar-Drysdale, B. (1990). *The Provision of Primary Experience*. London: Free Association Books
- .Greenberg, M., Cichetti, D. and Cummings, E. (eds.) (1990). *Attachment in the Pre-School Years*. Chicago: Chicago University Press.
- Jewett, C. (1984). *Helping Children Cope with Separation and Loss*. London: Batsford/BAAF.
- Lucas, M. (1992). Special Things: the management of an individual provision within a group care setting for emotionally disturbed children. *Therapeutic Communities*, 13 (4), 209-219.
- Lucas, M. (1993). *Understanding and Working with the Symbolic Communications of an Eight-Year-Old Girl in a Residential Setting*. Dissertation for M.A. degree in Therapeutic Child Care, University of Reading.
- Oaklander, V. (1978). *Windows to Our Children*. Utah: Real People Press.
- Owen, P. and Curtis, P. (1988). *Techniques for Working with Children*. 59 Cedar Avenue, Buxton, Chorley, Lancs.
- Redgrave, K. (1987). *Child's Play - Direct Work with the Deprived Child*. Cheadle: Boys and Girls Welfare Society.
- Rustin, M and M. (1987). *Narratives of Love and Loss: Studies in Modern Children's Fiction*. London/New York: Verso.
- Stern, D, (1985). *The Interpersonal World of the Infant*. New York: Basic Books.
- Ulloa, L. and Farnfield, S. (2000). Infant and Child Observation as Preparation for Social Work Practice. *Social Work Education*, 13 (3), 41-58.
- Ward, A. (1995). The "Matching Principle": Exploring connections between practice and training in therapeutic child care. *Journal of Social Work Practice*, 18, 49-60
- Winnicott, C. (1968). Communicating with Children. In R. Tod (ed.), *Disturbed Children*. London: Longman.
- Winnicott, D. W. (1965). *The Maturation Processes and the Facilitating Environment*. London: Hogarth Press and the Institute of Psycho-Analysis.
- Winnicott, D. W. (1971). *Playing and Reality*. London: Tavistock.

Recibido, 17 enero/2008

Revisión recibida, 18 febrero /2008

Aceptado, 20 marzo /2008