
Who's listening? The voice of the traumatised child

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Abstract

This paper outlines ways in which traumatised children remain invisible and argues that play is one means of giving children a voice in the therapeutic environment. It begins with a discussion of the ways in which children's trauma often remains invisible. It outlines briefly the impact of trauma and offers an alternate construction to the dominant discourse, arguing that each child's experience is unique and that his/her voice must be heard at each stage of the process if therapy is to be effective. The relevance of play in therapeutic work with children is then discussed, drawing on research and clinical experience to illustrate the significance of play in giving children a voice and achieving positive therapeutic outcomes. In the final section the implications for adults' interaction with children in other contexts is outlined and the implications for adult psychotherapy are also explored.

Definition of trauma

There are a number of definitions of what constitutes trauma and they share a common theme of trauma as an overwhelming event or series of events which renders the individual helpless. Psychodynamic definitions emphasise the overwhelming of defensive capacities (Goodwin: 1993: xxiv) while other definitions emphasise the helplessness experienced in the face of intolerable danger, anxiety and instinctual arousal (Eth & Pynoos cited in Armsworth & Holaday: 1993:49). Terr has combined these two elements in her definition: '...the mental result of one sudden, external blow or a series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations' (Terr: 1991:11).

Children may be exposed to one or more of the following: abuse (physical, sexual, and/or emotional); neglect; parental separation; multiple changes of address, school, household structure; living with parent(s) with substance addictions or psychiatric disorders; natural disasters; accidents; serious illness in themselves, parents or siblings; death of a friend or family member; bullying; witnessing violence at home or in the community; exposure to violence through the media. There is room for a wide range of opinion as to whether one or all of

these constitute trauma. Research on stress and coping indicates that individual children will differ in the extent to which they will experience these events as traumatic (Cairns: 1996; Monahon: 1993; Rutter: 1993). I have taken a broad definition of trauma which recognises that all of the above events have the potential to have a traumatic impact on children's lives, and I argue that paying attention to the child's voice is the most appropriate way in which to address issues of individual variation.

Impact of trauma

Case studies provided by practitioners are one of the primary sources of information about childhood trauma. These come from three sources: children who present in therapy as a result of single event trauma (Terr: 1990; Monahon: 1993); children who are referred for assessment and therapy as a result of behaviour and/or past history of trauma (Terr: 1990); and retrospective accounts of childhood experience presented by adults in therapy (Briere: 1992; Herman: 1992; Miller: 1985, 1987a; Terr: 1990). Three other sources of information provide insight into childhood experience: retrospective reconstructions based on public figures (Miller: 1987b); retrospective reconstructions provided through interviews with adults who have experienced trauma (Sanford: 1991; Sereny: 1998) and autobiographical accounts (Fraser: 1987; Johnson: 1995). All of these accounts bear witness to the profound impact of trauma on children's lives. Trauma in adulthood threatens our established patterns of coping and challenges previously held beliefs, whereas trauma in childhood may become a central focus around which the child's growing takes place, shaping and possibly distorting, their perception of themselves, the significant adults in their life and their view of the world.

Given this, you would expect that there would be considerable awareness of children's need for support and therapeutic intervention. This is often not the case. It is tempting to think that we live in enlightened times in which children get the help they need. In my experience this is not the case. Only a very small percentage of traumatised children get access to appropriate services. When I worked at Child, Youth and Family all of the children in care had suffered multiple trauma. Those that were referred for therapy were most often the children whose behaviour was the most challenging.

Invisibility

How is it that so many traumatised children remain invisible? To be visible traumatised children need to be recognised by the significant adults in their lives. Because they are dependent on adults for access to resources, parental recognition of their experience is a prerequisite for obtaining support. When a

child's experience is not validated as traumatic s/he may assume personal responsibility for this event. This can occur if the parent(s) does not know what has happened to the child, if the parent(s) denies that anything happened or claims that what happened was not important. When there is a conflict of between parents, or between a parent and a child, the child's perspective may be suppressed or ignored. Even when parents recognise that the child has been exposed to trauma they may block the child from having access to support. Sometimes parents actively resist intervention, fearing that their child - and themselves - will be retraumatized in the process (Schwarz & Perry: 1994).

Sometimes overwhelming trauma is not obvious in the child's behaviour and emotional responses. The child is assumed to be coping and the trauma remains invisible. Terr (1990) provides eloquent descriptions of children who have experienced trauma who did not give these signals. She also draws attention to the resistance which parents experience in acknowledging that their child may be affected by trauma. In her work with the parents of children involved in the Chowchilla kidnapping she discovered that many did not want to think of their children as suffering any negative consequences and accentuated the evidence that their children were coping (Terr: 1990:289-290).

Herman (1992) emphasises the extent to which children's dependence on parents leads them to adapt to abuse within the home in ways that preserve the relationship with the parents in spite of the abuse. It is therefore possible for a child's exposure to trauma to remain invisible. This is the most powerful way in which the child's voice is silenced.

Even when parents recognise that something is wrong, they may not be aware that the child is reacting to trauma. When children are referred to professionals it is usually as a result of their behaviour. Sometimes the referral is the direct outcome of a traumatic experience but more often referrals are made because behaviour is causing concern. Parents seeking help are likely to be referred to a mental health service or a social work service. The range of professionals offering such services includes psychologists, psychiatrists, psychotherapists, counsellors, and social workers. Each discipline has its own system for assessing and categorising the child and/or the family and this process shapes the response of the professional. The primary source of information is usually the parent(s) or caregiver(s). Information may also be sought from the school, family doctor or other agencies that have contact with the family. The child is not necessarily consulted. Smith (1996) notes the failure of social workers to interview children during care and protection investigations. Hall (1996) outlines the way in which concerns about children's memory and suggestibility have shaped re-

sponses to children in ways which may silence their voice. Glaser (1996) documents the vulnerability of the child in mental health settings and points out that there may be a lot of conversation about the child without considering either the child's view or the impact of being talked about. In these ways the child becomes invisible, or at best is seen indistinctly through a series of adult filters, despite being the focus for concern.

I have explored the reasons behind these reactions in another paper (Atwool: 2000). What I wish to explore here is that even when help is obtained the child's voice may not be heard. The children I work with rarely deal with specific incidents in an overt manner. Rather they bring issues, themes and concerns that recur in their play, their drawings and in their talking. This material relates to broad issues such as trust, conflict, self-esteem and self-perception. I have come to the conclusion that trauma is not experienced by children as a stand-alone incident or series of incidents. All that children experience becomes interwoven' and underpins their self-concept, their worldview, their feelings and their behaviour. What children bring to therapy is the sum total of their lives, not discrete issues or problems.

Furthermore they bring their unique subjective experience which may or may not coincide with the perception of the significant adults in their lives. Not only is the child acted upon by external events, they are also engaged in the process of interpreting these events and incorporating them into their worldview. Current intervention strategies are primarily based on single event trauma within the context of otherwise satisfactory lives. This creates a gap between theoretical formulations about the impact of trauma on children's lives and the lived experience of the children. This model is not applicable to those who experience single event trauma against a background of less than satisfactory experience, or those children who experience multiple and on-going trauma and fails to address the barriers which may prevent disclosure of trauma.

Importance of Play

Most of the children I work with have not experienced single event trauma. Many have experienced ongoing neglect, physical and/or sexual abuse, emotional abuse, changes in family structure and placement outside their family. In some situations detailed information about the child's experience during their early life is not available but their behaviour and emotional reactions are consistent with the experience of multiple trauma. It is not surprising that they do not present specific trauma related issues in their therapy. For these reasons I find play to be invaluable in working with children.

Significance of play for children

Childhood has been constructed as a preparatory stage for adulthood (Prout & James:1990; Stainton Rogers & Stainton Rogers: 1992; Mayall: 1996) and play is often dismissed as frivolous activity, something that we grow out of (Cattanach: 1992; Strom & Ray: 1971). It is seen to be a luxury and increasingly we are seeing children's lives organised into busy schedules of structured activity. However, an alternative view suggests that play is an intrinsic part of development and that adults might benefit from retaining aspects of play in our lives.

The role of play in child therapy

Play has been recognised as part of work with children as far back as Freud and the now legendary "Little Hans". It was first used in a systematic way by Hermine Hug-Hellmuth in 1920 and some ten years later Anna Freud and Melanie Klein both used play in their formulations of the theory and practice of psychoanalytic play therapy (Gil: 1991; Schaefer & O'Connor: 1983). It is important to note that they each used play in different ways, Anna Freud regarding play as important in building the relationship between therapist and child while Melanie Klein regarded play as the child's equivalent of free association. Since that time many different forms of play therapy have emerged including Virginia Axline's non-directive play therapy, David Levy's structured play therapy, gestalt play therapy, behaviour therapies, group therapy, and the incorporation of play in family therapy (Henderson: 2000; Gil: 1991; Cattanach: 1992).

Although there is considerable variation in the way play is used in different forms of therapy there appears to be agreement that play is the child's primary medium of communication and allows greater flexibility than reliance on verbal communication (Henderson: 2000).

Nickerson (1973) views play activities as the main therapeutic approach for children because it is a natural medium for self-expression, facilitates a child's communication, allows for a cathartic release of feelings, can be renewing and constructive, and allows the adult a window to observe the child's world.
(as cited in Gil: 1991:27)

Winnicott maintains that it is important to remember that playing is itself a therapy. He argues that "It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self "(1971: 54). Winnicott believes that play occurs in the space between the internal world and the external world. If we view childhood as socially constructed with the child being both active (operating from the subjective inner world) and acted upon

by the external world then it makes sense that play provides the medium through which these processes are managed. Play serves the same function for children as language serves adults in a postmodern analysis. Meaning and social relations are constructed through the process of language for the adult and cannot exist outside of language (Lyotard: 1984). Play serves the same function for the child. In other words play and language provide the mediums through which children and adults participate in, and construct the social processes that we call reality.

Winnicott (1971:38) states that “Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist”. This is perhaps the closest description I have found of my experience with children in the playroom. I know that I am least effective when adult preoccupations prevent me from entering into the child’s world. I also know that what children achieve in the playroom is the result of their own efforts. The therapist’s role is to provide the environment and the safety within which the work can take place. However, play has been so trivialised that it would be dangerous to assume that *all* the therapist does is play with the child. Knowledge and skill are required.

Children referred to therapy bring their own subjective understanding of reality (Atwool: 2000) and may be unable to comprehend even the simple rules put in place. Children behave toward the therapist in ways designed to evoke the responses with which they are familiar. Children who have experienced abuse may test the relationship repeatedly, unable to believe that the therapist will not hurt them or reject them. Children may feel helpless when the therapist does not conform to their expectations of adult behaviour and with this comes anxiety. One way to manage that anxiety is to attempt to regain control of the situation by provoking the responses that are familiar (Gil: 1991). Those of us who work with children are motivated by the desire to make their lives better and it can be very disconcerting when we find ourselves experiencing negative emotions. The work is often frustrating, as change may be a long slow process.

Trauma may inhibit play and sometimes the work is about helping the child rediscover the world of play (Winnicott: 1971; Gil: 1991). This can be a slow and confusing process as it feels as though nothing is happening. I have played endless board games with some children only to realise that these have provided a vehicle for the child to begin the work they need to do. Some of the greatest challenges for me have come from articulate children who are able to sustain verbal interaction for the whole session — the youngest of these was only four years old. It is tempting from an adult perspective to think that the work can

be done on this level. However my experience is that these children use verbal interaction as a defence and a way to avoid dealing with feelings and emotions.

It is important to remember when working with abused children that abuse is an intrusive experience and the therapy must be non-intrusive if it is to avoid reinforcing the child's experience of adults taking control (Gil: 1991). There is often an expectation that therapy will "fix" children who have experienced trauma. If adults assume that we have this power there is a high risk that we will subject children to processes that are intrusive and counterproductive. Sometimes children engage in repetitive re-enactments of trauma. Such play is not helpful to the child and may keep them locked into the trauma and associated feelings (Terr: 1990; Gil: 1991). Considerable skill is needed to intervene in such play and facilitate healing.

In choosing to work this way I have four primary aims: to provide a safe environment for children to do the play-work they need to do; to provide the child with the opportunity to express themselves in the way that is most comfortable for them; to allow a relationship of trust to develop in order that children are able to do this play-work; and to provide an opportunity for the child to learn about feelings and behaviour and find new ways of being.

Each child uses the therapist and the playroom in different ways. Some children focus primarily on play, often appearing to ignore me. Some children maintain high levels of interaction sometimes to the exclusion of play. Some children require my active involvement in their play, sometimes scripting me into roles that allow me to see how they experience their world. Because I have the opportunity to work with children long term I see children move through different phases in their use of the playroom. No two children are the same. There have been many moments of confusion and "not knowing" for me. Sometimes it takes several sessions for a particular issue to become clear and with some children I have sat through weeks and months of intense play, knowing that something of importance is taking place but not fully understanding until much later. What I have learnt is that I have to manage my "need to know" so that I do not interfere with the child's process. I also have to be willing to learn from them and not get caught up in my own expectations about how the therapeutic process should unfold. At the same time I have a responsibility to ensure that the process facilitates the child's growth and assists them in the resolution of the issues that led to their referral.

Before the work is complete it is important to assist the child in transferring their learning to home and to school. It is also important to ensure that adults

in these environments are receptive to, and supportive of, the changes the child is trying to make. No amount of therapy can make up for the lack of a “good-enough” family (Winnicott: 1965) and “good-enough” school environment.

Implications for parents, teachers, and other adults

In the final part of this paper I want to consider the implications of this way of working for parents, teachers and other adults who interact with children. I also want to explore the implications for work with adults dealing with childhood trauma. Much of the work involves being with the child while they play — sometimes in the role of observer, sometimes as participant, and sometimes in the role of helping the child make sense of their experience. When the primary issue for a child is an attachment difficulty I prefer to work with the child and the parent(s) or caregiver(s). In this situation the child is told that they are in charge and free to choose what they want to do; I encourage the parent to observe the child and only become actively involved when invited to do so by the child. This way of working is very effective and can facilitate change in the relationship within a relatively short time. When working in this way I encourage parents to look for opportunities to be with their children while they are playing at home. Sometimes when I am working with a child I suggest that parent(s) set aside five minutes each day to spend with the child. What is important is consistency — the adult does not have to do anything in this time, the child is free to use the time however they choose. Considerable patience is required but if parents persist, this technique often opens up possibilities for communication about matters of importance and leads to an improvement in the relationship. (Refer Donovan & McIntyre: 1990 for a description of this technique).

When I was growing up my mother did not work. From the time we got home from school she was often in the kitchen preparing the evening meal. This was a time when each of us took the opportunity to talk about our day — often waiting until no one else was in the kitchen. Many children today have parent(s) who are in full or part-time work outside the home. Many families do not sit down to a shared evening meal. Television and computer games provide passive forms of entertainment with limited possibilities for interaction even if there is more than one person in the room. Children are expected to complete homework from a young age and if they are also involved in structured activities such as clubs and sport the possibilities for unstructured, creative play are limited. Furthermore, parental concern about safety frequently means that children no longer have the freedom to roam beyond the immediate home environment (Valentine: 1997). If Winnicott is right, and play provides the

creative space in which we can discover ourselves, then today's children are severely constrained.

If there is no space within which to process the interaction between the child's inner and outer worlds then the child is likely to become reactive - constantly responding to external stimuli, whether that be the demands of adults, or television and computer games. It seems likely that the escalation of disorders such as ADHD, learning difficulties, and conduct disorders may be no more than the reflection of the world we have created for our children. Alternatively children may choose to withdraw into their own inner world, emerging only reluctantly to engage with the external world.

I believe adults are responsible for ensuring that children have the opportunity to play. As parents we need to make time to be with our children, not in highly structured "quality time" but simply at home and available, choosing to spend time being in the same physical space as our children. Outings in the outdoor environment are vastly preferable to shopping expeditions. We also need to respect the significance of play, not assuming that the child can just stop what they are doing when we want them to. Winnicott (1971) reminds us that playing is a preoccupation akin to adult concentration and that it cannot be easily left nor can it easily admit intrusions. I am sure that this suggestion will be met with derision from parents who envisage not being able to manage busy family lives. I am not suggesting that children be permitted to rule the household but rather that we are respectful and do not assume that what we want is automatically more important. When I work with children I let them know when there are five minutes left so that they can begin the process of disengaging. Children do not always find it easy to leave but this transition from the playroom to the external world becomes easier when they realise that they will be coming each week. I am sure that when children have confidence that there is space for their play and that this is respected they become more amenable to fitting in with household routines.

School is often characterised as being about work, not play and there may be a very clear demarcation between the classroom and the playground. However, play is work and the playground world may be as significant for the child's learning as the classroom. Furthermore, learning in the classroom may be greatly enhanced by incorporating elements of play (Strom & Ray: 1971). It is possible that bullying has become such a problem because adults have tended to be dismissive — just children playing — instead of looking closely at what is going on and the negative impact on both the victim and the bully. When children are having difficulty in the school environment they are unable to partici-

pate in formal learning. The whole environment needs to facilitate both learning and play.

Play is valuable in the therapeutic environment because it is such an important aspect of children's lives. Play is the primary medium through which all children make sense of their experiences and the world around them. Children deprived of the opportunity to play are unlikely to discover the sense of self that enables them to be active participants in social interactions. Instead they become withdrawn or reactive and their lives lack coherence and a sense of continuity. Play is a unique activity and the only parallel with adult work is that it is of equal significance. As adults I believe we have much to learn from children and we have much to gain from allowing them to lead us back into the world of play from which our own development emerged.

Implications for Adult Psychotherapy

I noted earlier Winnicott's statement "It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self (1971: 54)." In the adult world I think we are not always comfortable with this notion of play and there is a heavy reliance on verbal communication and cognitive processing. Even the psychodynamic therapies, which acknowledge the role of the unconscious, rely on accessing this primarily through verbalisation. Until recently psychology has relied heavily on cognitive-behavioural techniques which emphasise cognitive processing. However, there appears to have been something of a rapprochement between psychodynamic approaches and cognitive-behavioural strategies. Briere (in press: 3) in a recent paper outlining a model for treating adult victims of childhood abuse acknowledges the significance of material that is not directly accessible to the conscious. He identifies six areas in which childhood abuse and neglect impact on later adolescent and adult psychological functioning: negative preverbal assumptions and relational schema, conditioned emotional responses to abuse-related stimuli, implicit/sensory memories of abuse, narrative/ autobiographical memories of maltreatment, suppressed or "deep" cognitive structures involving abuse-related material, and inadequately developed affect regulation skills. Only the narrative/autobiographical memories are directly accessible in the conscious mind. Briere stresses the importance of recognising the survival value of many of the defensive strategies employed by adult survivors of abuse. His model emphasises the need to avoid activating these defences in therapy and he argues that therapy may require sessions over a considerably longer time. I believe that change in adulthood is so difficult to achieve because, as I noted earlier, all of the child's development

and growing is affected by the trauma. Verbalising within a therapeutic relationship may not be enough to facilitate change. Indeed, like the children I mentioned earlier, verbalisation may be a defensive strategy. In working with adults it is important to be mindful of the role of play in childhood development and exploring this aspect of client's lives may alert us to possibilities for other ways of working. Art and music are recognised modes of therapeutic intervention, narrative therapy highlights the importance of taking a 'playful approach' to problems, and gestalt therapy includes an action component. Because each client is unique I believe it is important to explore the range of interventions available, especially if it becomes clear that a client is stuck. Sometimes we need to bypass the conscious mind in order to open up to new possibilities. I have seen play facilitate change for adults participating in parent-child work and I see no reason why it may not be beneficial in some adult work.

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