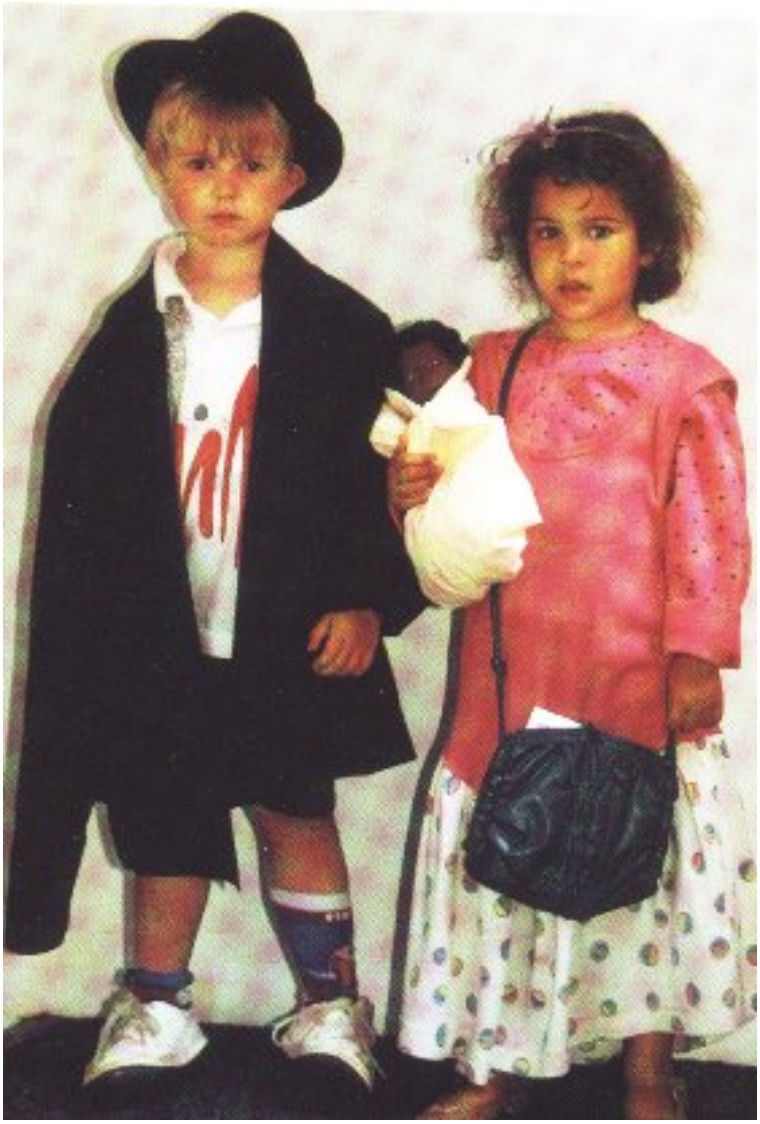
"Bonds and Boundaries"

- Child Protection and The Family -

Diana M.L. Birch



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- Child Protection and The Family -

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To My Family

..... The Good, The Bad, and The Ugly

"I was not brought into this world
to live up to your expectations,
And you were not brought into this world
to live up to mine -

..... I am me
..... and you are you

If we meet - that's wonderful
And if we don't - what the heck!"

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"What do we hope to achieve?"

To work in the field of child protection and particularly when it involves assessment of a family and possible rehabilitation is an area fraught with difficulties. It is certainly an area where 'wise men fear to tread'.

All families have problems of one degree or another. All children make their parents angry at times, most toddlers have tantrums, 'normal' married couples can have blazing rows, children will compete with each other for attention and little girls do have crushes on their fathers and get jealous of their mothers. Where do we draw the line, the boundary between what is acceptable and part of *the rich tapestry of life* and what is harmful, abusive and requires professional intervention?

And if we do intervene - how can we be sure that our intervention is helpful and does not in itself cause more harm than good?

The needs of the individual are not necessarily compatible with the needs of the group - in this case the family - and weighing up these needs and placing them in some order of priority can be nigh on impossible. It requires empathy and sensitivity - but most of all a high degree of professionalism.

The worst thing one can do is to 'feel sorry for' the young girl about to lose her child and to collude with her in covering up her deficiencies by being over helpful. That is not being kind or helpful - that is merely making her dependant and allowing a painful situation to continue until the inevitable breakdown. Certainly we must support her but teach her and enable her to grow stronger and more capable while she receives our support.

On the other hand it can be equally wrong to jump in too heavily with the sole aim of 'rescuing' a child from a harmful family - all the facts must be carefully weighed by the professionals involved and discussed with the family.

This professional weighing up of the facts in a case is very often conducted in a difficult and one could argue , entirely wrong arena. All too often cases go to court and are decided by the judicial system when a more informal , perhaps more caring approach could have brought better results. There is no room for the 'Perry Mason ' type confrontational approach in family and child care. Court action can be so distressing to a family that all chance of further work with them by the professionals involved is destroyed by the presentation of evidence.

For the professional involved in such work it can result in a feeling of reeling from one intense court case to another - Should this mother be allowed a chance to have her child back? - Should a child be brought up by her natural parent? Can you achieve good bonding after prolonged separation? Is a child more harmed by failed rehabilitation than no rehabilitation? Should a teenage mother be encouraged to bond with her child? What is the aftermath of parental loss?

Clichéd questions coming up time after time. Nevertheless hard to answer in the harsh glare of the court scenario when respected colleagues argue against each other - quoting contrasting literature and research findings with equal zeal. 'Zeal' is I feel, the right word for it - there are few areas where passion, and subjective fervour are more apt to cloud objective judgement than in that of child protection and separation of parent and child.

Certainly there is a difference in perspective - social workers do not want a dead baby on their case load and know the media will point the finger of blame in their direction; paediatricians may see neglected children gaining weight in hospital away from their families; child psychiatrists look at the disorganised family structure and find it hard to see a child being able to overcome parental patterns.

I wonder sometimes quite what we are hoping to achieve when we take the other view? What are we doing in our rehabilitation programme? With success rates running at perhaps 50% - if you're lucky and how do you measure success anyway? Varying criteria for selection for rehabilitation and no consensus on long term goals. Helping disturbed mothers parent disturbed children can seem a thankless task.

Unless you work with adolescents. That is when you begin to see the point. What do we see as the child reaches adolescence? And what happens when that child becomes a parent?

Removal from the family is sadly not a panacea - we see young people whose self esteem is in their boots - crying out to know why their families did not want them, why they failed their parents so badly - and often recreating their own family disturbance and imagined parental traumas in an attempt to understand and identify with their absent parents.

Mark was placed in care at the age of four, lived in children's homes and then a 'good' foster family. He did well at school and college, gained professional qualifications and then 'blew it all', lost his job, on the verge of divorce and with seething rage directed at his four year old daughter. He remembers nothing of his early life but his fantasy is that his behaviour was so bad that his parents had to send him away. He needs to somehow prove that his parents were good and he was bad by recreating the scene in this generation.

A teenage mother may well prove, with help, to be an excellent parent, able to meet her child's needs in a way that cannot be faulted. On the other hand she may be too much a child herself, needing love, care and attention which her child cannot supply.

The same situation could apply to a mother who is for other reasons unable to meet her child's needs - by virtue of mental or physical illness or deprived circumstances. It is important that such mothers and fathers be given the chance to explore their own potential - to be supported and encouraged and to be allowed to share in the decision whether to parent their own children or give them over to the care of another.

I know how grateful fourteen year old Kim was when I asked her if she would like me to find a foster mother for her child. She had wanted so much to please us all by being a good mother - but the depression and loss of herself showed through. At the court hearing they called her an unfit parent and brought up all her past delinquency - several months work on self worth destroyed in a day. But her little son will know, when he reaches his adolescence that he was a valued child, that his mother tried her best, and then gave him up in love.

I am constantly being told by my paediatric colleagues that good bonding between parent and child is essential for future mental health and that this can only occur in the first year of life - many authors have disputed this time limitation and even Bowlby has revised his views. However - even if this were so - surely the chance of establishing a rapport with your own

mother - at whatever age is preferable to whatever bond may be established with a stranger?

Winnicott once wrote a paper titled "Delinquency as a sign of hope". Rebelling, pushing out against the injustices that you have suffered in childhood - that is indeed a sign of hope - a sign that the spirit is not broken, that there is an individual in there shouting out "Hey! What about ME!" The beginnings of change, of a sense of one's own needs, of self worth.

Adolescence is regarded traditionally as a time of 'delinquency' and rebellion, a time of change and energy - both can be channelled in the healing process and that is often what makes working with young people so exciting. However the 'adolescent process' can be seen in many phases of change. An abused 'victim' who begins to assert himself, a 'battered wife' who gains the courage to leave her husband, a drug addict or alcoholic who decides to opt for a different lifestyle - all enter a new way of being - all experience the honeymoon elation of starting on a fresh beginning - they all in their own ways feel the exhilarating freedom of an 'Adolescence'.

Thus , just as for the adolescent, we can make use of this energy for change in the rehabilitation process for our damaged families. And , just as in adolescence, we must appreciate the stages of this process and work through them with our patients - understanding and support is the cornerstone - coercion and ultimata have no place in rehabilitation.

The damaged parent of whatever age, needs to go through a stage of being allowed to be the 'needy child' - for that indeed is what he or she is. Years of deprivation and abuse have usually taken their toll in terms of the individual's needs never having been met. A young parent generally becomes a young parent partially to find a way to fill this unmet need. A common mistake is to either disregard this need entirely, or to somehow expect it to be dismissed at will.

How often have we heard the expression that a parent is "Unable to place the child's needs above her (his) own". As if this were a conscious decision. OF COURSE they can't!.

The answer lies not in condemning this need, or pushing it to one side - but in fulfilling it. A needy parent is like an empty vessel , without caring or 'mothering' to fill the void - they have no resources - nothing to give

their children. So our first task is to accept the needs of the patient's inner child, to allow them to be child like and to parent them - often for the first time in their lives. Here 'dependence' is healthy and a required stage in the treatment process - however, like all good parents, we need to set boundaries and be consistent in our caring during this childlike dependency stage.

As the patient grows in trust and confidence, we also, as good parents, relinquish some control and responsibility so that our 'children' can grow up. Having had some of their own needs met, they can now look to their own children's needs - but gradually at first. We take them through Bowlby's 'exploring from a safe base' , we ARE that safe base. They go through an adolescence with us 'holding' and 'containing' their anxieties and gradually emerge as competent adults.

"Containment"

Let us not forget that all parents need a measure of 'parenting' themselves. Not just as a model, a way of building up the 'inner parent' by example as described above. But also when giving birth, at the time of becoming a parent, we also need to be cared for - to be 'mothered' or cared for by a loving partner.

Those who often need this most - our deprived or damaged patients, are those least likely to get it. And to make matters worse, they have far greater traumas to bear during the early months of parenthood - single parenthood, domestic violence, poverty, poor housing, inexperience etc. etc. In addition they will suffer greater stresses and assaults to their self worth and their parenting - criticism, children failing to thrive, childhood illness, professional intervention (usually perceived as unhelpful and critical), case conferences, child protection procedure and possibly court action or assessment.

It is too easy for assessment and observation to become negative, destructive and almost a sneer from the sidelines rather than a productive process. There is no value in watching a sinking man drown - if you see he can't swim, you throw him a life raft. So there is no value in purely observational assessment - seeing a faltering parent damage herself and her child holds no joy for observer or observed. Such an observer deserves to bear the shame of such failure and is a perpetrator of abuse to child and parent alike.

Assessment means 'working together ' to see what can be achieved and what can not. It is only in this way that a fair evaluation can be made of the situation and one that has a chance of being accepted by the family. So I suppose that I have answered my initial question "What do we hope to achieve?" - We hope to achieve a realistic appraisal of a families strengths and weaknesses; a forward plan which will best serve the needs of each individual within that family as well as the needs of the whole ; and an appreciation of the dynamics of the situation which is not based on blame, fault or failure, but rather on understanding, empathy and regard.

* * * * * * *

Emotional Abuse - the hidden scars.

"I cannot accept these conditions"

"..They have been accepted for you"

These were the words with which Kiril Lakota was released from seventeen years imprisonment in the film version of "The shoes of the Fisherman". .... So do we, as children enter the world; our conditions laid down for us. The emotional maelstrom into which we are pitched is beyond our control - we are wounded, react, build up defences and become battle scarred.

Emotional abuse is one of the categories officially recognised in Britain as a criterion for placing a child's name on a social services child protection register - but what is 'Emotional Abuse?'.

When I first held a workshop entitled 'Emotional abuse - the hidden scars' I had a fraught conversation with a doctor who wanted to know what the scars were and if he could learn how to find them on a child's body - it gave us all a good laugh - but in reality saddened me that the emotional side is so often forgotten in the search for evidence of abuse. And why do my profession, the medical profession, come in large numbers to my lectures on physical abuse and sexual abuse but drop out almost entirely on the emotional workshops? Have we trained a generation of doctors who cannot think holistically and instead look on the body as so many moving parts - or have we failed to prepare them for 'real life'. Are they as afraid of their patient's feelings as they are of their own?

Perhaps we should begin by considering how we define abuse? The very word 'abuse' carries a world of subjective feelings and ulterior motives. Does it convey a different meaning to different individuals - to the 'victim', 'perpetrator' or 'professional' ? The word has certainly been coloured by the isolation and shame of the victim; by the secret fear of the perpetrator and by the anxiety of the professional dreading a witch-hunt. Physical child abuse has gone under various labels - battered baby syndrome, non accidental injury, NAI to name a few. Whatever terminology we use, the effect on the child is the same ...

Abuse can be categorised under various headings
- physical, verbal, sexual, emotional
- are there others?

how about - neglect, starvation, ignoring, withdrawal, withholding.

What therefore is emotional abuse?

Perhaps if we consider that physical abuse is - assault on the 'person'- perhaps emotional abuse is - assault on the 'personality'. The whole manner in which that individual copes with feelings and everyday situations will be profoundly affected.

There will be damage to - confidence - self worth - ability to feel - ability to communicate - 'integrity' as a person. In place of confidence and self worth, there will be instilled - Fear, Guilt and Insecurity.

Obviously emotional abuse can occur with or without physical harm, although the converse is hardly possible. It is the emotional component of abuse which is potentially the most devastating aspect. This may result in damage on several levels - to the individual's present emotional well-being - in other words causing immediate emotional pain; hindering and injuring the child's emotional development and evoking maladaptive patterns of response.

Emotional abuse -> - harms present emotional well-being

-> - hinders development of emotional feeling self

-> - carries ' damaged pattern' of emotional response into adulthood.

We can be 'abused' or maltreated either by receiving something bad or by being deprived of something good. Hence, borrowing the terminology of TA (Transactional Analysis), abuse could be defined in terms of 'strokes'.

Abuse could be defined as either - giving negative 'strokes'
OR - withholding positive 'strokes'

Strokes are acts of recognition - acknowledgements of a person's presence or existence. They may be physical or verbal, praise or criticism. A human being needs a certain minimum number of strokes in order to survive - some people are 'programmed' to be able to survive on a very low level of strokes and some external strokes can be supplanted by internal strokes - but without strokes the individual is deprived and declines.

Negative strokes are better than no strokes at all. People growing up in an abusing situation are used to receiving mainly negative strokes, they grow to expect negatives, feel they deserve them and regard positives as suspect.

If an abusing world is the only world you know, that is your reality.

STROKES		
	positive	negative
Physical	Hugs	blows
Verbal	praise	criticism
	positive	negative
Unconditional	"I love you"	"I hate you"
Conditional	"I like you when you're sober"	"I can't stand you when you bite your nails"

Mechanisms of potential emotional damage can follow various routes viz.:- negative physical strokes causing emotional as well as physical harm - an obvious example being the emotional aftermath of a sexual assault; negative verbal strokes causing a negative emotional response as in a child taunted and called names by school bullies; or the neglected child who is deprived of love and positive strokes and thus suffers emotional starvation.

physical abuse =	-ve physical strokes	--> emotional harm
verbal abuse =	-ve verbal strokes	--> emotional response
neglect =	withholding +ve strokes	--> emotional starvation

Why are we vulnerable to emotional abuse? How do bad feelings begin? Emotional abuse begins at an early age - the seeds have to be sown very early on in life to 'prime' the developing personality to 'expect' further knocks. The first messages can be very subtle, almost going unnoticed ..

Imagine the baby. Lying in her cot.

..... when I'm hungry, - I get fed,

.....when I'm wet, - I get changed.

.....when I gurgle - they come to listen

..... when I smile, a loving face comes near to me.

..... I feel important, loved and wanted.

Then one day ..... I wake up, ... it's dark, the curtain's flapping .....I'm afraid.

I cry ..... nobody comes
..... I feel so alone ..... nobody wants me
..... I must have done something wrong
..... I'm not so important any more
..... I'm not worth loving any more.....

The child who grows up secure in it's relationship with mother - (with good object relations) will not be so vulnerable to emotional abuse. A child learns how to deal with emotions by using the relationship with mother or mother figure, as a 'prototype'.

Raw, primitive feelings, profound love, deep hate, cannot be held by the infant without the tempering effect of mother's reactions. The child projects his feelings onto mother who mirrors them back in tolerable form.
A child learns to love himself from the way he is loved by others.

If the infant can feel his mother's love directed at him, a unique new child, he will have the ability to develop a confident loving 'self', a self which is protected from the worst ravages of future emotional abuse. However if the child is unloved, ignored or finds himself wanting in his mother's eyes, he will be unable to find the strength and confidence to show his true self to the world and he will hide behind the shadow of what he thinks others wish to see - this false self is forever vulnerable to emotional trauma - the 'victim' par excellence.

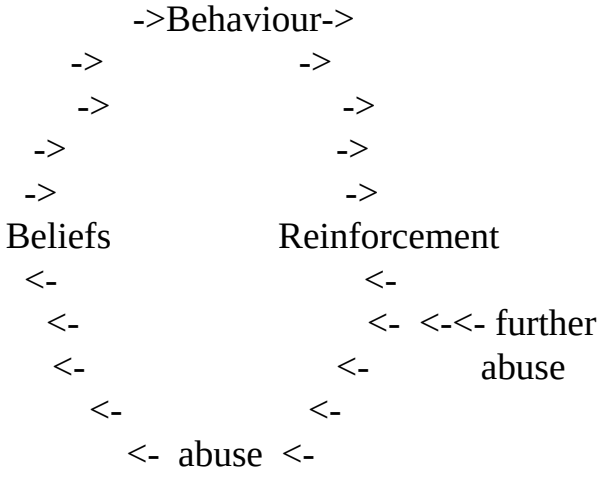
So the child will feel bad about himself, will feel guilty that he cannot make mother happy, and will be ready to meet the reinforcement of other abusing situations. He may be unable to show his real feelings, may substitute one (permitted) feeling for another (taboo) feeling. Not be himself.

"Why am I afraid to show you who I am?"

"I am afraid to tell you who I am ,
because, if I tell you who I am, you may not like who I am,
..... and It's all that I have"

In TA terms, the child acquires beliefs and makes decisions about what sort of person he is, what sort of a life he will lead. These are survival decisions - a child's way of explaining his problems, of coping with harmful situations and of setting himself a mode of behaviour. He makes these 'script' decisions at an early age and uses every life event thereafter to reinforce them and 'prove' how right he was in choosing his life's path.

Beliefs	**Behaviour**	**Reinforcement**
A 'Script' Beliefs and feelings	B Repetitive Behaviours	C Reinforcing Memories
Assumptions & feelings that limit options considered possible in life.	Self defeating and frequently result in confirming a persons worst fears and negative beliefs	Experiences that are selectively remembered and often emphasised which prove or justify the life position.
beliefs about - self - others - life - destiny	observable behaviour patterns	Recall emotional memories evidence and justification
primary feelings extreme - rage terror despair	'scripty' Fantasies	"There you are - that goes to show"



Reinforcing memories are selectively remembered, just as reinforcing events are subjectively regarded. Everything which 'fits' with the script decision or they way we feel about ourselves is taken on board, emphasised and used to underline and justify the position.

Anything which does not fit is discarded and ignored. Hence the child who felt she was bad and worthless will become the adult who cannot accept compliments - "She's only saying that to be nice, it's not really true" but whose supertuned senses pick up every whisper of a slight or derogatory comment "There you are, I knew she didn't really like me".

Emotional abuse can be overtly manifest in hatred and rejection, or subtly wearing away like water dripping on a stone. In whatever degree however it alters the child's very being and leaves a legacy to be carried into adulthood.

Ruth, said of the bullies in her school -

"They changed me, that's what I can't forgive or forget. Whatever happens to me now, whatever I do, I can never again be the same person, or the person that I would have been if I had not been put down and afraid all that time".

Just as adverse situations can cause emotional harm, so favourable conditions can help heal the wounds. We can use such therapeutic events to aid recovery.

Perhaps the easiest way to understand the process is to see how it affects ourselves. Emotional 'abuse' is part and parcel of living. There is no human being on this earth who has not suffered in some degree from emotional trauma, it is merely a matter of degree. Hence each of us has a part of ourselves which can empathise with our more seriously affected companions.

How would we answer the key questions which indicate the factors keeping our own 'merry-go-round' turning? What would the beliefs, behaviours and reinforcements be for ourselves?

What do you believe about yourself, others, your life. Are you a successful caring person, are you a failure, do you feel good about yourself, do you feel good about your life? Do you believe things usually

turn out well for you or do you generally end up making a mess of things?

What situations do you keep finding yourself in? Do you keep giving in to people or find you've been made a fool of? Do you always find yourself in conflict with a dominant boss? Are you always left 'holding the baby'?

Which scenes in your life keep replaying in your mind? The time you got lost in the shopping precinct and separated from your mother (reinforcing rejection), the time you broke your grandmother's favourite vase and hid the pieces (reinforcing guilt).

- Key Questions -
A 1 What do you believe about - yourself - others - your life How do you feel about those beliefs? 2 Do you believe things always turn out in a certain way for you?
B What situations do you keep experiencing over and over again? Do you find yourself saying "Here I go again!"
C What life events seem most significant to you? What do you keep remembering?

Having identified 'script' beliefs which are binding us in the pain of emotional turmoil, we can now intervene, challenge these beliefs and release ourselves from the treadmill of repetitive harmful behaviour patterns.

Why do we believe we are bad? - Of course we are not 'bad'! - Look at all the evidence that we are as good as the next person, ... or even better!.

There are alternative interpretations of past events.

As children we often took two and two and made five, interpretations and conclusions made in the past may not hold up to the vision of the present. There are also alternative ways of behaving in a given situation, we do not have to always react in our well rehearsed 'scripty' manner. Alternatives may first have to be tried out as 'homework options' before they can be utilised naturally.

Similarly the significance of past memories must be challenged and alternatives suggested. Could the memory, with a subtly different 'selection', also reinforce the opposite premise?

Suppose we were to even make up an alternative ending to our childhood 'remembered' stories? How about if the frog got the princess for a change. Suppose grandmother hated the broken vase and only cared in case you had hurt yourself? What if you were a confident explorer in the shopping precinct and mother praised you for your initiative while being overjoyed to find you again?.

Intervention
A Challenge beliefs B Stop behaviour options - homework C Challenge memories significance opposite experiences create new endings to stories

The transition we need to eventually make is from a 'victim' position of "I don't like being abused" - (But can't do anything about it because really I deserve it) - through a midway position of "I don't deserve to be treated badly" to a self confident and self appraising position of "I deserve to be treated well!"

----> "I don't deserve to be treated badly"

"I don't like being abused"

----> "I deserve to be treated well"

* * * * * * *

"Working with Families - How not to perpetuate the abuse".

The following is based on a workshop setting designed to help professionals to make positive interventions with families where child protection has been important.

Introduction -

The way in which we handle families and individuals within those families, have far reaching effects on the way that family will function afterwards.

However much we may disapprove of or be at odds with a family's structure and functioning, we must realise that the child has been brought up within that structure and will have to survive within it after the 'professional' intervention is over.

In addition since this family structure is the only one the child has known; the way that child perceives his world is based on this blueprint - all the child's 'survival tactics' are based on this reality.

We cannot destroy the child's environment without replacing it with something else and without realising and appreciating the 'dynamics' of the situation.

Altering the structure or dynamics can leave members 'exposed' and unearth other conflicts.

this can be desired -> used in therapy
or undesired -> recreating the conflict
from a different base. (false cure).

* * * * * * *

Family structure

A family is structured around it's own ethos - it may be an emotionally distanced grouping of individuals who constitute a 'family' in name only and where the individual feels no support or bonding with his fellows.

Alternatively, as is more common in many of the families coming under professional scrutiny, it may be an enmeshed body which takes on an existence of it's own and where individual personalities are lost in a common boundary-less ego.

So called 'normal' families fall somewhere between the two extremes but are still prone to power struggles between the members - who is in charge, who is the spokesperson, who is the scapegoat? Family members assume or are pushed into a role and interactions between family members are influenced by these roles and by the interplay between them - striking up allegiances, involving one another in power triangulations and using one another in indirect communication.

How often have we heard a child used in something like - "Tell your father if he wants his dinner he had better come home on time".
or a parent implicated in indirect communication as in -
"Wait till your father gets home" or "What will your mother say when .."

Families frequently take sides - with one child siding with mother and another with father, or all 'ganging up' on the weakest member. In 'abusive' families a child frequently appears to side with the abusing parent against the other - since this is the safest thing to do.

It is worth while taking a little time to consider some examples of this - think of the last two families you worked with and how they functioned - consider also your own family of origin - what part did you play? This topic can form the basis of an excellent role play with colleagues in a workshop situation.

The family is a microcosm of the outside world and of the wider environment. The way in which we learn to function within our families, provides the 'blueprint' for how we function in society at large.

We carry our family 'role' with us from our family of origin to school, to our workplace , to relationships and social settings and to our eventual roles in the family we create. The stability of maintenance of a role and 'place' within the world, of being secure in the knowledge that things turn out or people behave in the way we expect them to do - this is the most important factor in family life.

Stability and predictability are more important than the quality of that condition. In other words the secure knowledge that mother loves you is

certainly conducive to mental health and well being - but so, in a perverse way, is the secure knowledge that father will hit you every time he comes home - as opposed to the insecurity of not knowing whether he will or not.

There is nothing so destructive as the insecurity and unpredictability of not knowing whether for instance dad will be drunk or sober when he comes home and thus whether he will hit you (perhaps when you have been good) or hug you and give you a present (maybe when you have not had such a good day).

If your behaviour has no predictive consequence - then it has no importance. And if your behaviour has no importance, then perhaps you do not either. The child's self worth is destroyed because nobody cares what he does or how he acts. It is as if he does not exist.

This is no less the case for those unfortunate children who are raised in families where abuse - physical, sexual or emotional has taken place.

Sarah had been sexually abused by her grandfather since the age of 4 or 5. In common with many victims of sexual abuse, she was unable to 'disclose' what was happening. She at the same time could not believe that people - her mother, her aunt and her grandmother could not 'see' her distress and acted as if they did not know.

She began to act out the anger and frustration she felt in delinquent activity - smashing windows on her estate and minor acts of vandalism. This did not get her into trouble, people did not seem to notice. There was no consequence to her behaviour - just as there appeared to be no consequence to her grandfather's behaviour.

Later, as an adolescent, Sarah's rages became more intense. She walked a long distance with a knife in her hands , wanting to kill her grandfather. When she arrived she saw her grandmother and could not commit the deed. She thus went home, smashed the family home and was committed to a mental institution. She calmed down and was released. Another example of missed communication.

In adult life during therapy she went into an 'uncontrollable rage' one night and smashed windows in the treatment unit. The following day she doggedly refuted that there was any possible consequence to her

behaviour. A breakthrough in therapy occurred when she was faced with possible consequences and a code of 'acceptable behaviour' was laid down. It was as if at last 'it mattered' what she did and therefore 'she mattered'.

* * * * * * *

Problems of the 'meddlesome ' worker

When working in child protection - there is an intense desire to 'do something' - it is thus very easy to take action just so that this need can be fulfilled and the professional can be 'seen to be doing something'. Under such pressure however there is a very real danger that the 'something' can be of no use whatsoever to the child needing protection or to his or her family - and can at best be useless and at worst harmful and dangerous.

Some of the aftermath of 'meddlesome activity' in child protection is not immediately apparent due to the flawed manner in which much child protection work is conducted - i.e. that of crisis intervention based mainly on protection from harm without follow up or any treatment process to 'heal the wounds' . Hence the total gamut of the inflicted harm is not appreciated nor the contribution within that wounding process which can be laid at the door of professional error or misjudgement.

Hence , when we feel urged to 'do something' - it is imperative that we consider for whose sake we do that i.e. are we being helpful to the client or 'helpful' to ourselves?.

In looking at this dilemma , it is useful to consider a concept borrowed from Transactional Analysis (TA) - that of Karpmann's drama triangle. The 'Drama Triangle' can be used to look at roles in any situation where a psychological 'Game; is being played ; in other words, where two people are not being straight with each other, not saying what they really mean. In such 'Game play' the roles of Victim, Rescuer and Persecutor are played and switched by the participants in a manner that can leave both feeling uncomfortable.

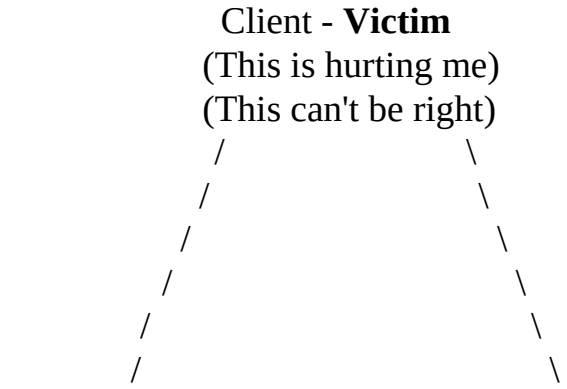
A classic 'family view' of the triangle in action is provided by the alcoholic family. A common scenario might be - drunken husband (Persecutor) comes in late and berates wife (Victim) for not having dinner ready; she (now Persecutor) then turns on him (Now Victim) for being drunk again ; he then throws up and complains how ill he feels so she

'Rescues' him by sympathy and cleaning up after him and probably rings his boss in the morning to tell him her husband has the flu'.. thus enabling him to continue in his behaviour pattern and Persecute her all over again.

In our scenario of the 'meddlesome worker' one might play the game with the professional as Rescuer turning Persecutor. In such a situation the term 'Rescuer' is not complimentary , such a person 'Rescues' for their own personal ends and their actions are generally harmful to their clients even though superficially they might fool some of the people some of the time.

The Rescuer begins by making the inappropriate intervention in the vein of the dentist telling the patient that 'It won't hurt' or the old fashioned school teacher caning the pupil with a 'This is for your own good and it hurts me more than it hurts you' attitude.

When the client, hardly surprisingly, fails to respond to such treatment; the Rescuer becomes Persecutor, blaming the client for lack of response rather than seeing that his methods might be flawed. This is akin to the Doctor blaming his patient for failing to get better rather than stopping to consider that the 'cure' might have been the wrong one.



Persecutor - - - - - - - - **Rescuer**

(This is for your own good) (I'm only trying
(I know what's best for you) to help you)
(I'm an expert in this field
- you'll ruin my reputation).

* * * * * * *

Case Histories -

The following case histories illustrate a number of difficulties faced by workers and the contrasting possible end points which could be brought about by insensitive or inappropriate action. The cases are based on true facts although one end point actually happened , and the other was fabricated. Sadly , the end point which I would have liked to see happen is the fabricated one.

Unfortunately we work in an age when the very words 'child abuse' can engender such subjective response from professionals that interventions are often less than ideal and once the hot potato of abuse has started rolling, albeit in the wrong direction, it can acquire a momentum of it's own and be impossible to stop or to shift onto a more appropriate course.

Hence ill thought out actions, however well meaning can have devastating results for the child who has been the victim of abuse and for it's family. It is thus that our interventions can be in themselves abusive. As they say "The path to hell is paved with good intentions".

Please read through the case histories and evaluate how you would have acted. Discuss the two possible endpoints.

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Case History 1 - Margaret, Harry and Tom.

Margaret had her first baby when she was in her late thirties. Her husband was a business man who spent a lot of time away from home on business trips.

In the weeks after the birth, Margaret was tired, lonely and depressed. She had not expected to have a child at this stage in her marriage and had not imagined that her life could be so changed.

One night, baby Harry seemed to cry incessantly. She did not know how to pacify him. Margaret eventually managed to get him to sleep and , just as she was dropping off herself - he started to cry again. She picked him up roughly and shook him, crying, "Please, please stop it" - she pushed

him back down into his cot, ran crying into the next room and shut the door on him.

The next morning, Margaret found that Harry had two tiny bruises on his cheeks - she must have handled him more roughly than she thought. She wrapped him up and rushed round to her GPs surgery.

A. The GP examined the child, found light finger tip bruising on the cheeks, and no other signs of abuse. Harry was well nourished and developmentally up to date.
He did seem to be a 'windy' baby however and so advice was given about feeding regimes to try and reduce his indigestion and night time colic.

The GP also diagnosed post natal depression, which was contributing to Margaret's low threshold of tolerance and which, combined with her excessive tiredness, was diminishing her supply of breast milk and thus contributing to Harry's fractiousness.

It was arranged that the health visitor call regularly on Margaret to help her build confidence in handling her baby. He knew that this was a long awaited child and felt Margaret may be feeling a sense of anti-climax ad failure in not being able to be the perfect mother. The GP asked her husband to take some time off work to allow Margaret to rest.

B. The GP found finger tip bruising on the baby's cheeks and questioned Margaret about it. She was distraught and confessed that she had handled the child roughly and had shaken him.

The doctor had recently moved into the practice and did not know the family, he was very concerned about Harry and decided that since he was born late to a professional career oriented couple, he was probably an unplanned and possibly unwanted child.

The child was sent to hospital for X ray studies and Margaret was cross examined by the Casualty officer, followed by the paediatric houseman, registrar, senior registrar and consultant. The hospital social worker came and asked if she understood about the child abuse procedure in their district.

The social worker then telephoned Margaret's husband, Tom who was embarrassed to be summoned out of an important meeting because a place of safety order was being taken on his son.

When Tom arrived at the hospital, he was not immediately able to speak to his wife or see his child, first he was cross questioned about his wife's character, her history and whether he thought she was capable of injuring her baby. Tom was devastated. Margaret confessed, she felt like a criminal.

It was several days before they had Harry back, and then they were told he was on the 'at risk register'. Margaret's depression got worse, she could not cope. One night she took an overdose, Tom came home to find Harry crying alone and his wife semi comatose. What danger Harry was in!

Margaret started seeing a psychiatrist who gave her tablets which made her more sleepy and less able to cope. Tom thought it best that Harry go and stay with his parents, who knew how to look after children.

The marriage did not last long after that. Margaret was branded as 'unsafe' with children. Tom had to change his job and is now less well paid.

What of Harry?

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Case History 2 Ann and Zoe

Ann had been in care for most of her life. She did not really know what family life was like, it had been one children's home after another.

When she fell pregnant at 17, she desperately wanted to make a go of her life, to bring up her child herself and to learn how to be a better mother than her own mother had been.

The pregnancy was unplanned but the baby was wanted. Her boyfriend Dave was supportive although he did not have a job and so could not help much.

Ann had been abused as a young child and had been on the social services, child abuse register. When her child was born, her social worker thought that her child was therefore at risk of being abused - abused children become abusing parents.

A. Baby Zoe was placed with a foster mother; Ann fought to have her back. She was given the task of 'proving' herself. Could she be a good mother, did she know how to handle a baby?

So every weekend Ann was allowed to 'handle' Zoe under the supervision of a social worker. She picked up the unfamiliar bundle and did not know what to do - criticism followed criticism - she was set up to fail.

B. Ann and Zoe were placed in a residential unit together. Ann was given support in caring for her daughter and was gently allowed to assume responsibility for her care as her confidence grew.

Zoe was on the social services 'child protection' register but after six months the authorities were happy that Ann could cope with her child and plans were made for return to a flat in the community and eventual de registration of the child.

Thus what might initially appear to be merely a subtle difference of emphasis in dealing with a case can have far reaching and devastating consequences for the child who we are aiming to protect and the family who we can either support and 'nurse' to psycho social health or who we can very easily destroy.

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Sexual Abuse

Consider the case of a sexually abused child who 'discloses' to a professional.

How do we stop him or her from being further abused by the consequences?

What are the further possibilities for abuse?

1 - **GUILT** at having been the victim - it must have been my fault somehow.

2. Being seen as **accuser** - accusing 'family' and mother or carer of not protecting her enough.

3. Breaker of family - perpetrator - father possibly - being removed from family - **break up** of family his or her fault.

4. Made to testify - **witness** of fathers or family's guilt.

5. **Physical** abuse - the examination itself can be 'abusing'.

6. Circumstances of examination and disclosure can be an **abusing ordeal.**

7. **Court** appearance and evidence giving can be traumatic.

8. Abuse in **not being believed** or not taken seriously.

9. Having to **'confront'** perpetrator or argue what did or did not happen.

10. possible further abuse in terms of what happens if child placed **back in contact** with abuser - revenge, blackmail, etc.

11. Professionals involved giving **covert messages** - e.g. why don't you retract and make life easier for everyone - perhaps you exaggerated?

12 Or c**overt disgust** at the circumstances of the abuse being 'misread' as disgust for victim?

13 What of the 'stigma' of being an abuse victim?

There are a number of further possibilities which might arise in discussion. It is worthwhile pausing to consider - what could have been abusive in the last case you were involved in? Could this have been circumvented in some way?

Let us reconsider the last question -

What of the 'stigma' of being an abuse victim? - This point is often glossed over; because the logical 'thinking part' of the professional may regard it as monstrous that anyone could regard the victim as at fault or stigmatised in any way.

However, the victim does feel different, soiled by the process; the family often marginalise and scapegoat the victim- "It's all her fault!". "If she had not been abused we would not have lost our family !"; Society is by no means neutral in this process and victims of child abuse, particularly sexual abuse are stigmatised in a variety of settings.

I have known nurseries where children have been stopped from playing with others because of the 'risk of inappropriate sexual play' - schools where similar things have been said and where parents have even removed children when they have found out that a sexually abused child sat next to theirs in class.

Outrageous? Yes, of course!

But nevertheless there is an illogical, one could say 'primitive', subconscious part of ourselves which can feel that a sexually abused child

is different, is tainted by the process. ..... And that this impairment or contamination can somehow spread?

It is akin to the contempt held in some societies for girls who have lost their virginity prior to marriage. The 'primitive' feeling that even the rape victim is somehow rendered guilty by the loss of her purity and chastity. Add to this the widespread taboo against incest and we have a very powerful psychological message - 'This child is unclean!'

Regarding abused children as 'damaged goods' is thus a deeply ingrained psychological feeling. For the professional to deny that such a feeling exists is as damaging as the victim's denial of what has happened to him or her. Children instinctually pick up and tune in on adults feelings about them - a child will realise that a teacher regards him as different, ... that his best friend's mother will not let him go to tea .....

It is important to confront such feelings and to work through them honestly and without reproach. It is our duty as professionals to work on our own feelings first and then to discuss and confront such difficulties with others involved with the child. - To allow a class teacher to voice her misgivings without fear of condemnation and to then learn to understand them; .... understand their origins and to work through to a more helpful and realistic viewpoint.

Only by performing this 'groundwork' can we fully understand our children's feelings and help them to expurgate their guilt and self disgust.

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Conclusion

All intervention both effective and ineffective is going to produce change - either in the individual or in the family. Change is painful - it is often easier to stay with the status quo than to risk the uncertainty of change and 'moving on' even if we are moving to a healthier position.

The arguments put forward here are not intended to deter the professional from making interventions - many of which are essential to safeguard the welfare, and sometimes the lives of children.

It is hoped however that the measures we take are positive and helpful to the families we work with and that if we have to cause a measure of harm and distress in our interventions; that we are at least aware of such injury and can act appropriately to minimise it's long term effect.

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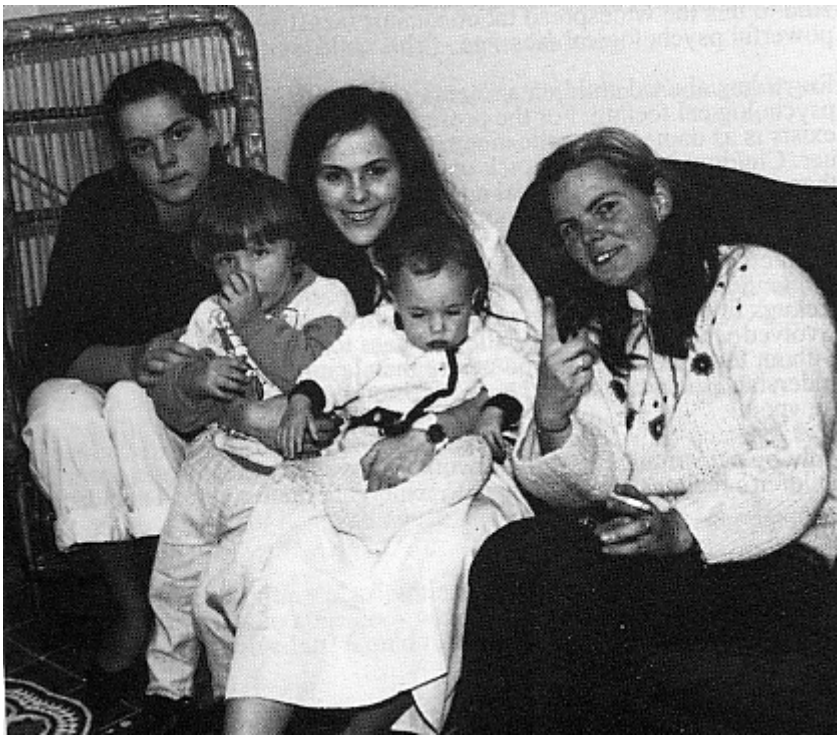

Three Generations - Transgenerational Bonding

"Working with the family that is not there"

- The Philosophy of Youth Support House -

Child protection, risk assessment, family rehabilitation - three of the cornerstones of our work at Youth Support House.

The abused child or victimised young person is very much a 'product' of his disordered family of origin.

Ideally one might wish to work with the family as a whole but more frequently we are presented with teenagers and young adults who have little or no contact with their families. Strategies have therefore been developed within Youth Support to work on these issues when parents are not in evidence.

Youth Support House is run as a therapeutic community.
All our transactions with residents, patients and clients are based on psychotherapeutic principles. This means that not only are residents involved in formal therapy 'sessions', but that everyday living experiences and conversations are used as opportunities for informal therapy.

The type of client who we often see at Youth Support and particularly our teenage residents, do not always respond well to formal therapy such as sitting in a room with a therapist for an hour of individual work - they are not able to keep up regular appointments and their attention span is often short. Interpretations are not always acceptable. They do not often understand therapy.

'Active' therapies are useful - art therapy, drama and dance/ movement therapy are obvious examples - but just as an activity can be used therapeutically in such disciplines, so everyday activities can be a focus of therapy in a unit such as Youth Support.

The following chapter provides a guideline as to the philosophy of therapy and care within the unit taken from the direction of working on the family background.

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Working with Families?

When working with disturbed teenagers our motto should be **Ignore the family at your peril!**. Should we however aim to work with the family or in spite of the family?

Traditionally the family therapist works by assembling the whole family in a room and observing and perhaps 'conducting' their interactions. There obviously needs to be a considerable degree of co-operation in this process and it must be said that a fairly high proportion of family therapy is conducted in the private sector where motivation to comply with therapy is high.

What can we do when families have no wish to 'interact' in a goldfish bowl or when family tensions and perhaps violence are so strong that the therapeutic situation cannot hold them?

I would suggest that the alternative is to work **'through the family'.**

In working with young people from very disturbed family backgrounds or in situations where they have been removed from their family of origin we can work through the family by observing transference issues.

Freud was the first to formulate the concept that emotional illness developed **in relation** to others. Thus arose the idea that it was possible to heal or modify the relationship by creating a 'therapeutic' relationship with a therapist from which parallels could be drawn to help the patient. This **'transference'** process involves two aspects - the therapists **interpretations** and the patient's learning how to cope with situations by **inference.**

Patient <----------> **Relative**

| | | **transference** | | |

Patient <----------> **Therapist**

In working with **the family that 'isn't there',** transference ideas can be applied to the 'group' both in the formal sense of the therapeutic groups

within the unit and informally looking at interactions in the 'living space' of a residential setting.

This works both ways. By observing emotional reactions and interchanges the family norms and beliefs can be postulated. While at the same time knowledge of the family background can help us to understand disturbed patterns of behaviour. Looking at this in one direction only i.e. listening to only one half of the story can lead to pitfalls in interpretation.

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Example 1.

Ann was placed in our residential unit after a long history of abuse of both herself and other family members by several male relatives. She had a child by her stepfather and the father of her other three children, whom she had married, was accused of sexually abusing her younger sister at age 14.

In the unit Ann was never able to express her opinion on things, she would never take sides. If there was a dispute between residents or someone was accused of breaking a rule her reaction was always 'Well, if they say that has happened, then that must be so, Maybe someone has done something wrong but it's none of my business really, maybe I would have done the same'. She always spent time with other girls who were distressed and generally acted as peacemaker.

Ann's behaviour in the unit paralleled her position in the family - she had been frequently pressed into taking sides - ..... either with mother who tried to maintain a facade of caring, despite having exposed her children to repeated abuse; ..... or with stepfather who had abused her; ..... or with her husband against her sister ...

She was caught up in the double bind of feeling guilty at having been abused and feeling sorry and responsible for the abusers. Thus she was condemned by her social worker for not having denounced her husband when he raped her sister and similarly condemned when she looked after her uncle after he had been found guilty of incest.

In a family where there was no security and no idea of whom to trust, Ann could not know which side to take in order to survive.

Therapy thus centred on correcting Ann's functioning within her 'replacement family' - the unit - by encouraging her to trust that she would not be abused, feel safe in expressing herself without criticism, and to be able to develop self confidence - and subsequently to enable her to use this new role in the 'real world'.

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Example 2 -

In Tracey's case - knowing half the story resulted in a partially erroneous interpretation.

Tracey had been in care all her life while still maintaining some contact with family. She was a very needy, immature young lady.

Her story was that her mother had abandoned her and run off with several younger men. At times there had been reconciliations but swiftly followed by another affair and the children being abandoned again. Tracey described her mother as a 'slag' (promiscuous slut) who had even gone to bed with her social worker.

Tracey's behaviour in the unit deteriorated suddenly after she had been discovered with a boy in her room and simultaneously seemed to have been 'ditched' by the father of her baby. She attacked her care worker , a young woman, and accused her of sneaking men into the house and sleeping around. On several nights she kept everyone awake by hammering on the staff doors shouting 'slag, slag'.

The initial interpretation, based on what Tracey had disclosed in therapy, was that she was torn between being *different from* her mother, being a good mother to her own baby, and ending up *like* her mother - she was afraid of becoming a 'slag', felt an inevitable pull to follow that path and seemed to be accusing others of the very thing she was afraid of becoming.

Tracey commonly used this tactic of displacing and projecting her own feelings and fears onto others.

The other side of the tale emerged after contact was made with the social worker who had supposedly slept with Tracey's mother.

It appeared that the family were under the strong influence of a bullying father who continually berated his ex wife and had built up a family myth of the abandoning, sluttish mother. In fact he had been the one to abandon the children and had also abused them.

The family pattern was to avoid getting close to 'mother' and when closeness was threatened, to break up the relationship with accusations against the carer and disruptive behaviour aimed at fostering rejection and break up of the 'family' unit. Tracey had repeated this pattern in other homes and foster situations when she had caused breakdown of all her placements.

Understanding this mechanism enabled us to show **solidarity** within the unit thus confounding her wish to break us up, continue to show **caring and consistent** reactions to her, thus not being manipulated into rejecting her and **confronting** her false allegations with statements of fact.

Solidarity <----------> **Break up**

Caring <----------> **Rejection**

Truth <---confrontation---> **Falsehood**

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In assessing the family functioning and teenager's roles within the family we have various levels to consider. -

Our patients are often teenage mothers hence we begin on the level of the

'**immediate family**' - i.e. girl - baby ....boyfriend

these are influenced by the

'**family of origin**' girl - parents ..siblings

and on a deeper level by

Transgenerational issues

and are mirrored in the

'**transplanted family**' - girl - adoptive parents
girl - residential staff

It is possible to view many of the concepts of family therapy in the context of the 'transplanted family'. Let us consider some of the issues which are prominent in the type of family seen at the Youth Support unit.

Boundary issues.

Many of the abusing families, such as Anna's have almost non existent boundaries. There is poor differentiation between individuals with a tendency for personalities to fuse - the situation has been described as an 'undifferentiated family ego mass' (Murray Bowen 1978).

Boundary issues operate on :-

intergenerational level - invisible loyalties and indebtedness - (c.f. Anna letting Uncle stay)

personal space -intrusions and invasions (incest)

emotional space no room for own feelings

Information space -live by others opinions - mother answers questions
If there is too much enmeshment -there is a loss of autonomy
if the individuals are too disengaged - there is loss of intimacy.

In a disturbed family the teenager can oscillate emotionally between these two extremes thus avoiding any real commitment to a relationship. Both extremes are equally painful.

We frequently see the teenager who is so needy and attention seeking that he engulfs anyone coming close and more or less 'devours' the unsuspecting care worker. ... Then, just as some true closeness might be on the point of developing, there is sudden reversal, with sabotaging behaviour and an intense rejection of attention - a move to .... "reject you before you can have the chance to reject me!"

The boundary issue is seen to operate very qraphically in the interplay between teenage mother and baby. Tracey showed an almost complete symbiosis with her baby, who was almost used as a coat hanger - something to hang her feelings on - something to wear her watch, to look pretty for her, to put on more weight than the other babies, to laugh or be sick when Tracey wanted to attract attention or disrupt a conversation.

In the residential setting, interpersonal boundaries must be scrupulously adhered to and echoed by consistent handling in terms of house rules and 'professional' caring.

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Triangulations and Collusions

In many of our families 'straight' communication between family members has been difficult. The young person has often been used as a pawn in communication issues. Patterns may involve triangulation's whereby parents avoid direct transactions by relating through the child or collusions when the child is made to side with one parent - often the abuser - against the other. Thus Tracey sided with Father against her mother.

These patterns, if repeated in the residential unit can be extremely destructive. Our clients are masters of **manipulation** and will consciously and subconsciously be continually attempting to triangulate and collude - setting up one staff member against another. We need to be constantly aware of these mechanisms and avoid being enmeshed while maintaining close communication on an open 'honest' level.

It cannot be overestimated how powerful the pull to follow disturbed patterns of behaviour can be and how much energy our patients use in trying to ensnare us - trying to make us behave like the family of origin.

Our **staff support** group often dwells on this issue alone and is vital in maintaining care workers morale - it is the easy path to allow girls to **recreate their family of origin -** it is a tough order to maintain the integrity of **'our family'.**

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The technique of **cross confrontation** is of value in family therapy - i.e. showing family A who is unable to express feeling how family B is able to do so and is not destroyed by the process.

The Youth Support Family

The residential Unit can function on this level by demonstrating how this 'transplanted or substitute family' can cope with emotions, can handle family secrets and can accept the young person as a valued individual no matter what his or her background might be - can do this without being destroyed by the process - and moreover can emerge still caring for and accepting of the young person in its care.

Family of origin

Family A
- afraid of emotions
- destroyed by emotions
- release of family secrets = destruction
- rejecting if above taboos broken

| | | | | | |

cross confrontation

| | | | | | |

Substitute family - unit

Family B
- encouraging show of emotions
- surviving emotional outbursts
- not destroyed by disclosure of secrets
- not rejecting

Hence the residential unit can operate as a **therapeutic community** in which by applying the principles of family therapy and transference issues teenagers can be helped to work through the emotional scars of disturbance in their family of origin even in the absence of the family members.

Bonding, Separation and the Rehabilitation process.

The first step as you know is always what matters most when we are dealing with those who are young and tender.
That is the time when they are taking shape and when any impression we choose to make leaves a permanent mark

Plato 428-348 BC

"Bonding"

What do we mean by bonding?

The term has been used fairly loosely to describe the close relationship between mother and child but there are numerous aspects to the concept which should be separated out.

The common practice is to speak of bonding as a reciprocal process but it is more correct technically to distinguish between bonding and attachment. Classically the term 'Bonding' applies to the feeling of the parent for the child - while the child demonstrates attachment to the parent.

BONDING PARENT ---> ---> ---> CHILD

ATTACHMENT CHILD ---> ---> ---> PARENT

Bonding is thus the sense of parenthood, or motherhood which is engendered in the parent and which invokes protection and caring. This is perhaps most easily demonstrated in the animal kingdom where the primary carer - usually mother, but in some species father, will go to any lengths to preserve the offspring - to the extent of facing starvation and mortal peril.

This process in animals is generally limited to a critical time period and is probably almost wholly hormone or pheromone mediated. A Siamese Fighting fish father will care for his hatchlings, driving off the predatory female until they reach a critical size and then he becomes a predator himself.

A ewe will only suckle a lamb which 'smells right' and drive others away. For centuries shepherds have coated the fleece of an orphan lamb with the smell or pheromones of it's replacement to prevent rejection.

Human beings have a habit of considering themselves 'above' nature. Instincts are considered base and primitive. But in this early bonding of mother and infant perhaps we do not pay nature sufficient heed.

It is accepted that premature babies and those in intensive care after birth bond less easily with their mothers and the incidence of rejection and abuse is greater in such cases.

Surely it should come as no surprise that babies born into a sterile clinical environment with mothers who have to maintain a gloved or masked and certainly 'clean' distance cannot get close enough to their mothers, often don't smell right and do not engender the 'primitive' responses in their modern mothers which would be vital for their survival out in the 'real' world.

It is patently obvious that some wonderful mothers bottle feed their infants - but surely the hormonal responses to a baby sucking at the breast must enhance the early bonding process. A mother deprived of this stimulus by virtue of a baby being tube fed will undoubtedly experience difficulties.

The birth process and the moment of birth are also profoundly important - seeing and handling a new-born baby is an experience that can never be supplanted. Modern techniques ensure that mothers can see the birth - sometimes via mirrors - Caesarean sections are no longer usually performed under general anaesthetic and the mother can remain alert with use of epidural techniques.

Nevertheless, despite the obvious importance of these first moments and early weeks of close mother / child bonding, some of these responses can be elicited at a later stage.

Foster mothers who have not been through the incomparable experience of birth may have quite marked emotional responses to the children in their care. The vicinity of a small child can arouse 'instinctual' feelings which can be difficult to comprehend. - the colloquially described 'broodiness' of women can be a very real albeit somewhat irrational phenomenon.

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" I found that as I handled the baby and let him cradle against me, I felt very protective towards him, almost 'over preoccupied' with him - totally absorbed.

I kept telling myself that this was a professional relationship - that I would only have the baby for a few weeks and that I should not get emotionally involved - but it was as if my body had taken over - I felt I was operating on my instinct.

When I was bottle feeding him and he leaned against my breast I really felt as if I was going to produce milk - my breasts tingled and felt heavy.

It was a very worrying reaction really - I was a bit scared by how strong the feeling was!"

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Mothers who have been deprived of their children in the early weeks or months for some reason or another can still experience 'good bonding' with their infants. It would seem that the important factor is the mother's emotional state and her capacity to 'keep the child alive' in her thoughts during the separation.

An illustration of this point - a sad tale with a happy ending - was provided by the unfortunate abduction of a baby from a maternity ward. In the case of the baby Abbie Humphries this abduction took place when the child was only four hours old and thus at a time when the parents were experiencing this very important first stage of bonding.

The mother had not had time to get over the trauma of birth - she was going through the stage of 'happy

exhaustion' - holding her new-born and getting to know her when a bogus 'nurse' removed the child.

It took more than a week to recover little Abbie - but anyone seeing the pictures of the reunited family could see immediately how emotionally close mother and child were and I suspect they will be all the more inseparable due to the separation - as they say - 'absence makes the heart grow fonder'.

Too often I believe , the experience of mother child separation and the damage to the bonding process has been observed in mothers who may have had little emotional investment in their children in the first place. The reasons for separation and the timing and manner of that separation have not been taken into account.

A mother who does not have 'maternal feelings' , who does not really want to be a mother or who does not really want the child will not bond with that child whatever the circumstances and however much attention is given to enhancing their closeness. The same applies to the father.

In contrast a mother or father with an emotional investment in parenthood, with a good internal image of their 'fantasy child' - may have been deprived of their child, - may not have been allowed the positive experiences of the birth, by virtue perhaps of illness or other factors, - may have been separated for many months from their child - but these parents will still be able to bond closely with their child.

I have heard professionals speak of mothers and fathers 'establishing good bonding' after a separation. I would suggest that where there is good bonding - In fact they do not bond on being reunited with their child - they have already bonded during the separation.

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" ..... . Unfortunately Tessa could not stay in the children's home after the baby was born and we did not have an alternative placement for her and the baby - so she stayed on in the home and the baby went to a foster mother.

We have been trying to persuade her to have the baby adopted - she is really too young and at the age of sixteen I don't think she could take the responsibility.

Amy is six months old now and Tessa has had only two contact visits each week because the foster mother is quite a distance away.

I was very wary of allowing this trial at rehabilitation - I was sure that there could not be any bonding between her and the baby and I thought the whole experience would be damaging for both Amy and Tessa - trying to push a relationship which had no substance .....

.... but I have been amazed to see that they are very close and there does seem to be reasonable bonding."

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Attachment

We have discussed thus far the process of parent 'bonding' to child. What of the other side of the coin - the 'attachment' of child to parent?

We owe the most important work on attachment to John Bowlby who developed the concept of a 'secure base'. The child is at first wholly dependant on mother (or parent figure) - by achieving security with this warm, stable mother, the child can then develop the confidence to explore his environment from this 'safe base'.

He explores, safe in the knowledge and security that 'mother will always be there' - at first just venturing a very short distance from her - within touching distance so that he can maintain physical contact ..... then a little further, glancing back at her ..... then a little further around a corner perhaps .. at first checking that she is still there but then able to go further afield - always safe in the knowledge that she will not leave him.

A child who is thus confident will be firmly attached psychologically to the parent and will be able to carry that security with him throughout life - to use in confident exploration of his environment at later stages - going to school - exploring and experimenting at adolescence - getting a job, leaving home, starting his own family.

Separation from mother is possible because there is security in the stability of the attachment. Similarly such a child will be capable of forming stable attachments and relationships in adulthood.

In contrast, the child who has no safe base from which to explore the world will be ambivalent - is mother going to be there or not? Should he be close to her and risk abandonment? Or is it better to be 'anxiously avoidant' in other words not risking repeated rejection by allowing her to get close to him again.

The child who has been abandoned and rejected becomes increasingly avoidant of further overtures of supposed closeness and his anxiety increases markedly under repeated threat of abandonment. (Pauline De Lozier "Attachment theory and childhood").

Classically the view of attachment is that the baby starts off life as 'everybody's friend' and cannot really distinguish between one carer and another until approximately 3 months of age and will go easily to different carers until about six months of age.

A three month old child can recognise mother and a six month old is wary of new faces.

The statement that a baby does not recognise mother until three months of age does however disguise certain other factors of paramount importance. We must not forget that a baby does not 'meet mum' for the first time at the moment of birth. There have been nine months of sharing the same body space, hearing her heartbeat and bathing in her hormonal 'soup'.

At birth she is no stranger.

The early period with mother sets the scene for the way an individual learns about the world, about relationships and about feelings - this is the 'space' in which we develop object relations - we learn about good feelings and bad feelings.

Hence the quality of this early caring is critical.
(see also 'Inner Worlds and Outer Challenges' Birch 1992)

- Attachment -

0-6 months everybody's friend

3 months recognises mother

6 months fear of strangers

9-12 months maturing relationships

There is a danger in being too simplistic in analysing infants' responses and attachment. In a residential setting for instance or within a nursery situation, a baby will respond positively to a number of carers.

I have heard this interpreted negatively as baby responding to a number of carers , hence 'attachment to mother' must be impaired. I would argue strongly that this is not so. The baby will still be able to distinguish between mother, preferred carer and others.

Assessment of bonding

The observation of children and their parents and the assessment of levels of bonding and attachment has never been easy. There is a general level of consensus in published research but discrepancies and differences of opinion abound.

What makes an adequate mother and what constitutes good bonding?

Adequate mothers .... Felt and expressed pleasure in the activities of mothering , showed awareness of baby's affective states and willingness to respond to them - ..... they USED the heightened anxiety normal in this period in the service of the baby. (Robertson 1961).

Certainly the early weeks and months with a new baby can be a very anxiety ridden time - particularly if this is a first baby. A measure of anxiety can be described as positive concern - the heightened awareness necessary in order to become tuned in to the child's needs and to respond adequately.

However, when difficulties arise and stresses can become too great... Anxiety in the mother can make her withdraw from the baby. At such times her own problems, her own fears can overwhelm her preoccupation in the baby. The child's needs are placed in a secondary position to her own.

* * * * * * *

Marie had a mental health problem - she was diagnosed as Briquet's syndrome - in other words she had very high anxiety levels and 'hysterical' outbursts.

When in a relatively calm mood, she was able to use her anxiety in the service of her baby ... but when stressed she was unable to cope, had a hysterical outburst and her anxiety reached overwhelming levels causing a cut off of feeling for her child.

At such a time it was her, Marie, who needed love, caring and attention and she had none available to give to her child.

* * * * * * *

Similarly, anxiety levels can be high in disadvantaged mothers. We can easily sabotage their mothering abilities by increasing their anxiety levels if we are putting on pressure for them to succeed. Fear of failure as a mother or as a father increases anxiety as does the feeling that one is being 'watched' and judged.

Hence the need for empathy and understanding in the assessment process.

How do we assess?

Klaus and Kennell (1983)"Bonding - The beginnings of Parent- Infant attachment") underlined that in assessing bonding and attachment one must "..... Distinguish attachment from attachment behaviours (bonding) - Fondling, kissing, cuddling, prolonged gazing. ..." In other words , seeing parents 'do the right thing' does not mean that the emotional side of the relationship is going well.

Certainly in the assessment situation we do frequently see parents 'go through the motions' act as they think we would like them to or fake it with their children. Some of this is a calculating act of deception - but there are also other times when it is clear that the mother or father do actually know what to do and do perform the acts which would normally indicate closeness - such as holding and kissing - but where the acts are sterile and devoid of emotion.

I would suggest that in such cases the very performance of a loving act in the absence of 'good feelings' is not only an indication of lack of bonding - it is also frankly abusive.

* * * * * * *

David wanted to prove he was a good father. He was a very selfish young man who had no comprehension of the emotional needs of his children.

At access visits and during assessment sessions he would play boisterously with his children - throwing the baby up in the air , making an enormous point of kissing and hugging - but sessions were devoid of affect.

With his older toddler he would 'use' the child to demonstrate his paternal skills - tickling him to show that he laughed - holding his legs to show he could play football.

The reality was that the children froze when he kissed them and shrank from his touch - hence even a kiss was in this case abusive.

All the bonding or attachment behaviours were there but there was no attachment.

* * * * * * *

Similarly Robertson described 25 mother/ child pairs where the ability of mothers to show appropriate affect to their children resulted in adequate bonding. In five of the 25 babies development was poor and they received inadequate mothering. Their mothers responses to them were poor and lacked meaningful affect. In the other 20 cases the mothers had personality defects but nevertheless responded well and appropriately to the baby and the babies development was normal.

Mothers who suffer post natal depression can , by virtue of their illness, be unavailable to the developing child and thus the bonding process could be impaired - however in the first two years of life it has been suggested that children can respond even to a severely depressed mother -

" .....Infants achieve their sense of unity and harmony with a depressed mother ... by producing mother's mood themselves. ..... . Mothers become concerned because babies are fretful - this made them feel that

they didn't like the baby and thus guilty because they were not good mothers. ... " (Anna Freud 'Discussion of Bowlby's paper' Psychoanalytical studies of childhood 1960).

Such mothers and their children respond well to treatment. The mothers who suffer from 'bipolar' depressive illness - i.e. swinging from manic to depressive phases - have the worse outcome at long term follow up - presumably due to the inconsistency of handling. (E James Anthony 'Effects of maternal depression' in 'Children of depressed parents').

Enhancement of Bonding

So how do we foster or influence the bonding process?

Bonding can be fostered at various stages -

Before the pregnancy and before conception bonding can be enhanced by planning for the forthcoming birth. A wanted and planned child could be said to have bonded in fantasy to his parents even prior to his conception.

During pregnancy by confirming and accepting the pregnancy - the parents re-establish their wish for the child and the mother will allow herself to feel close to the foetus - welcoming her bodily changes and enjoying her pregnancy. The quickening of foetal movement confirming ... "Here I am Mum!"

Difficulties can arise here in the case of the young mother who denies her pregnancy, hides her growing abdomen, wishes not to be pregnant - thus denying the existence of the baby who will soon be blocked out of the arena of early bonding.

This process continues throughout labour and birth. Again, perceiving the foetus as an individual will aid the recognition of this little human being who has needs of his own.

Mimicking good mothering behaviour and modelling oneself on good mothers, aunts and grandmothers helped many young mothers in past generations to achieve 'good enough' bonding with their new-borns. Extended families provided opportunities for 'surrogate' motherhood as young women baby sat for younger siblings and cousins many of whom might have been born at home under the fascinated gaze of the older children.

This is no longer the case - families are smaller, the nuclear family is often cut off from former generations and babies are born in remoter hospitals.

"..... Pregnancy is a normal event but birth is a 'crisis' or turning point, many are unprepared for mothering and attachment is difficult. Not enough girls see children during adolescence." (Brazelton TB 'The early mother infant adjustment')

The only births that children are likely to see are the birth of household pets - and even there our modern society with emphasis on flats and lack of pets precludes many young people from experiencing closeness with new-born and growing animals. This is a feature of our programme at Youth Support House - that children and teenagers - particularly abused and neglected young people should experience handling and rearing young animals - puppies - rabbits - to foster the 'bonding' with warm, responsive but also dependant and needy young.

Learning to parent

- Enhancement of Bonding -

- before conception - planning for the baby

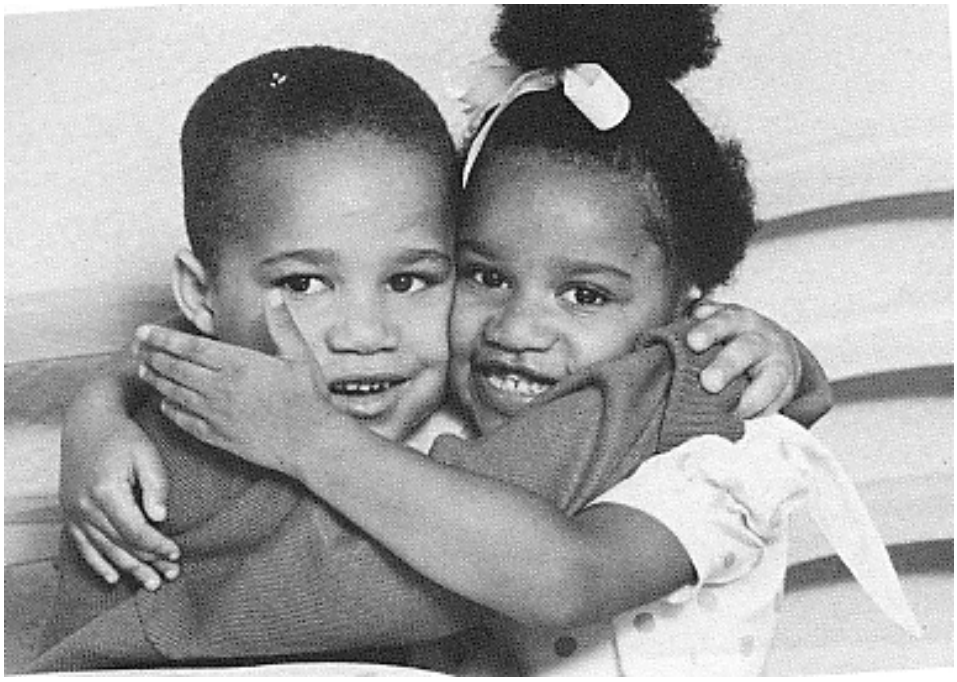
- during pregnancy - accepting pregnancy
  - foetal movement

- labour . birth - perceiving foetus as individual

- after birth - seeing touching and caring
  - accepting baby as a separate individual

In the days after the birth contact with baby, seeing touching and caring, feeding and again accepting the infant as a separate individual continue to strengthen the bonds between parent and child.

During these first weeks it is normal for the mother to be totally absorbed in the needs of her new baby more or less to the exclusion of all else. This is the stage of "Primary Maternal Preoccupation" which Winnicott (1958) described as a 'normal psychotic state' where the mother is totally engrossed with her baby. This is a necessary stage ensuring maximal contact between mother and child while an emotional bond is forged.



Bonding in Action

"..... We seek always to teach by example, not precept. By discussion, not instruction. .. The more we can give young people opportunities to meet with and observe at first hand how sensitive, caring parents treat their offspring, the more likely they are to follow suit...."

'A secure Base' John Bowlby 1988

First Love

We have said that part of the bonding between parent and child is an emotional response - so when does love first appear on the agenda?

Many mothers do indeed love their babies before birth or even in fantasy before conception. The general popular opinion seems to be that all mothers 'should' love their babies at birth - but this is by no means the case.

Mothers who find the early days hard and cannot feel love usually feel intense guilt over their absence of 'maternal feelings' - they feel abnormal and that they are failures.

Such early feelings of failure can , if unchecked, set mothers up to fail in their mothering - failure breeds further failure. The recognition that many mothers feel that way, that it is natural to have to 'grow to love' your child can help parents shed this guilt and get on with loving their children.

When 97 Oxford mothers were asked the question - 'When did you first feel love for your baby? ' Fourty one percent said during pregnancy; twenty four percent at birth ; twenty seven percent in the first week and eight percent later than one week. (MacFarlane 1978 'The relationship between mother and neonate').

In confirmation of these findings Kumar and Robson ('Delayed onset of maternal affection after childbirth') found that 40% of their sample of mothers were indifferent on first holding their baby

First Love

Pregnancy 41%

Birth 24%

First week 27%

Later 8%

40% of mothers felt nothing on first holding their baby

Separation

When a child is separated from his or her natural parents, the bonding and attachment processes are interfered with. A great deal of theorising and debate centres around the issues of -

How does separation affect the bonding process?

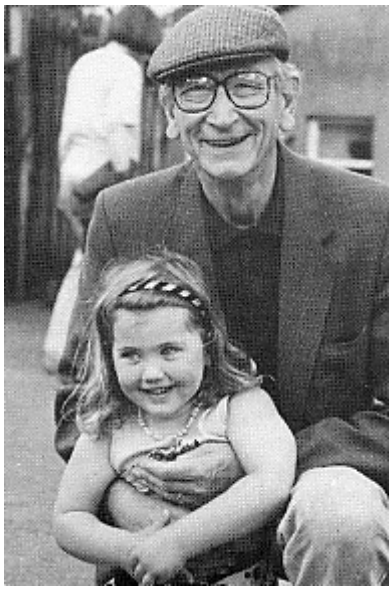
To what degree is the bonding process affected by separation?

Is such an effect permanent or recoverable?

Is bonding possible at differing stages of development and at different ages?

In animals there is usually a critical period during which attachment to the parent can occur - the classic example which is always quoted in this context is that of Geese who will bond to the first living creature which they see after hatching and will only do so within the first few hours after birth.

Human beings are not Geese - our young do not fly, lay eggs or live on water - so why should we have similar attachment theories? Bonding is a phenomenon which does not only occur between mother and baby - it is important in maintaining all the family and social relationships which form part of human society.



Children develop close relationships with mother, father and grandparents also. Teenagers develop close bonds with peers and later adults 'bond' with their partners in order to produce new families. Hence the human animal is capable of 'bonding' at any age - there is no 'critical period'. It follows that contrary to a wide body of opinion, a child can forge an attachment with his mother at a stage beyond the first year of life provided the circumstances are right.

*"Human development is a slow process of genetic and environmental interactions with sensitivities (rather than critical periods) for different processes at different times." (*Ann M Clarke and ADB Clarke "Early experience , Myth and evidence" 1976)

It has been held that the childhood attachment characteristics outlined by Bowlby of 'Avoidant' ; 'Securely attached' ; or 'Ambivalent' are probably fixed by one year of age - but are modified by two years. ("Infant and childhood depression - developmental factors" Wiley) - Also that by the age of two years at least one third of the variance at adolescence is predictable in terms of dependency, aggression, intellect. (Bloom "Stability and change in human characteristics").

In contrast Rutter ("Maternal Deprivation reassessed") has taken Bowlby's ideas and given contrary evidence for the need of early good mothering.

Hence what is the effect of separation of mothers and children and is this change irreparable?

Research papers on this subject are difficult to interpret and compare because the groups of children described have all been separated from their mothers for varying lengths of time at differing ages and periods and dates varied. Moreover there has generally not been an allowance for or explanation of the quality of care the children received before , during or after separation.

It has been shown that children's development slowed after maternal deprivation by separation during hospital admission - BUT that this fall was followed by a rise in developmental attainment if mother reappeared. (Spitz 1945/46 'Hospitalisation' Psychoanalytical studies of childhood).

This has also been our finding within the residential unit at Youth Support - that children whose developmental progress had been impaired by separation from their parents, improved during the rehabilitation process and showed large gains in attainment with restitution of their mother. (vide infra).

The deprived adolescent has also been shown to be *"..... very much less impaired than would have been expected from Bowlby's original theory"*. (Clarke and Clarke "Recovery from the effects of deprivation".) It was thought that children compensated for a poor early start if their homes were later caring.

Possibly what follows an early experience of neglect, deprivation or separation - may prolong what would otherwise be transitory effects - good or bad of those early experiences.

In this respect the child is not stuck in a static, passive role - he is in a fluid situation - in a state of flux - child and environment reciprocally affect one another. The child responds to the environment and his personality is moulded by the experience of his environment - but at the same time the child interacts with and has the capacity to modify his environment.

This situation parallels views of the way a deprived child 's learning skills are influenced by his environment. (Rutter 64) -that *" ..... the child is in a dynamic situation and causes its own learning..."* The question is - does the early environment have a disproportionate effect? Currently there is no evidence to support this supposition.

Dynamic Relationship

..>..>..modifies..>..>

Child Environment

<....<.learning.<...<.

Another piece of evidence in favour of the idea that children are not at their most vulnerable in the early years of life comes from the National Child Development Study. Which looked at reading ability at seven and at eleven years - comparing social classes I and II with social classes III and IV. At age seven there was a loss of 0.9 years - at age eleven a loss of 1.1 years. Hence the effect of adversity and social deprivation from ages seven to eleven was even more pronounced than up to that age - i.e. from birth to seven years.

So far as rehabilitation with parents or 'redressing the harm' - the older child has also been shown to be accessible - Twelve studies of intervention with families in improving social conditions and providing rehabilitation for families with problems resulted in a positive effect with children up to six years of age. (H Bronfenbrenner "Is early intervention effective?"). In addition adopting older children aged five to twelve years has just as good an outcome as adopting infants. (Kadushin "Adopting older children")

Symbiosis and Separation.

There are some situations where mother and child seem to be so closely 'bonded' that there is almost no 'space' between the two beings - mother and infant seem to fuse - the appearance is of 'over bonding'.

However this symbiotic state is indicative of lack of true bonding.

In order to be able to bond with a baby - you have to first be able to perceive that baby as something or someone outside of yourself - a separate individual - a person in their own right.

Bonding with a baby involves first changing the mental image of the baby from the expected, fantasised position during and before pregnancy to the real situation - a live separate child.

baby --> expected --> real

The very young, deprived or disturbed mother may over identify with the child in the womb - confusing their own psychological 'inner child' with the actual growing foetal child - and later after delivery and childbirth progressing to confusing the baby 'out here' with their own 'child' ego - 'in there' .

We have mentioned earlier how very young children develop 'object relations' - we learn about the world around us and internalise the good and bad as 'internal objects'.

* * * * * * *

" ..... The baby asks for attention by crying, smiling, coughing and later vocalising.

A fortunate child will receive an appropriate response which makes sense and thus aids his understanding of the world, whereas the unfortunate baby will receive the 'wrong' response or no response, leaving him confused and disturbed.

We all receive some inappropriate responses since mothers are not perfect and the needs of a child can be easily misunderstood. A child's demands must also to an extent be frustrated if he is not to continue as a demanding omnipotent tyrant.

The mother will be seen by the child as being good, nurturing , provider of all nourishment, when she is meeting the baby's needs at times such as feeding. In Kleinian terms, she is then seen as the 'good breast'.

When she is withholding, frustrating the child and not fulfilling his needs, she is seen as the 'bad breast'.

When mother is doing something good, she is good, and when someone is doing something good to you, you feel good, you become good. Hence the good part of mother becomes part of the inner world of the baby.

The same happens when mother is being 'bad'. Hence good and bad sides of mother represent 'internal objects' for the child.

At first the child cannot integrate these together. A young baby can adore the 'good mother' and then murderously hate the 'bad mother' without being able to see that both are parts of the same person. Later he may fear that he has harmed or destroyed the good while attacking the bad or that he may have exhausted or consumed the good breast by his greedy demands.

Keeping these opposites apart is useful in avoiding the conflict inherent in integration but stops the child from developing a well functioning inner self "

(Inner Worlds and Outer Challenges - Birch 1992)

* * * * * * *

Thus in teenage mothers when we find intense symbiosis and apparent 'over bonding' - the problem lies in non separation - not perceiving infant as individual. It is almost as if there is a fault in the young mother's object relations - as if the baby becomes a transitional object.

Winnicott believed that the capacity to use an object is based on cross identification or empathy - otherwise described as the ability to 'stand in someone else's shoes'

In the case of symbiosis we have a situation of over identification . There is a confusion between HAVING the baby and BEING the baby

The baby becomes the good internal object within the womb -

If the internalised early environment is poor, for example, if the mother has had a deprived or abusive early childhood - the mother has difficulty in producing a whole live child in fantasy and this leads to difficulty in the relationship with the child.

The very young mother who is symbiotically fused with her baby will never put the child down - carries the child around continuously - sits the baby on her lap while she is eating - gets the baby to do things 'for her'. For instance cry for her, laugh for her, - she uses the baby in communication - projects her feelings onto the child - buys expensive trainers like her own for a child who is not yet walking - plays rock music to her - puts pop group badges and insignia on her ... etc. etc. The baby is merely an extension of her persona.

How do you separate from or cope with separation of a fused child?.

This can sometimes be catastrophic - conflict inevitably arises as the child grows older and asserts the independence of a toddler - complete symbiosis can easily become complete rejection when the 'object' no longer fulfils it's role'

Another baby - a replacement object may follow.

Winnicott describes a very dramatic displacement of the fused infant by a psychotic mother who threw her baby into a canal as the only way she could achieve separation! ("The effect of psychotic parents on the emotional development of the child")

This inability to perceive the baby as an individual in his own right and thus an inability to see the child as he or she is - the false perception of the child is fundamental to many instances where the child is later abused.

Children can be abused because they are not what their parents want them to be - they do not match up to impossible expectations - within this concept the abusing parent may be over dependant on the child and the outcome of the symbiotic phase may result in the child and mother mixing their roles within the disordered family structure.

> *" ..... Abusing mothers are "..Prone to periods of intense anxiety , impulsive, immature .. their dependence needs are exceptionally strong but they are extremely distrustful ... having no one else to turn to, may seek care and comfort from one of their own children whom they treat as though they were much older....."* (Morris and Gould 'Role reversal - a necessary concept in dealing with battered child syndrome').

Further discussion of the role of separation and identity follow in a later chapter.

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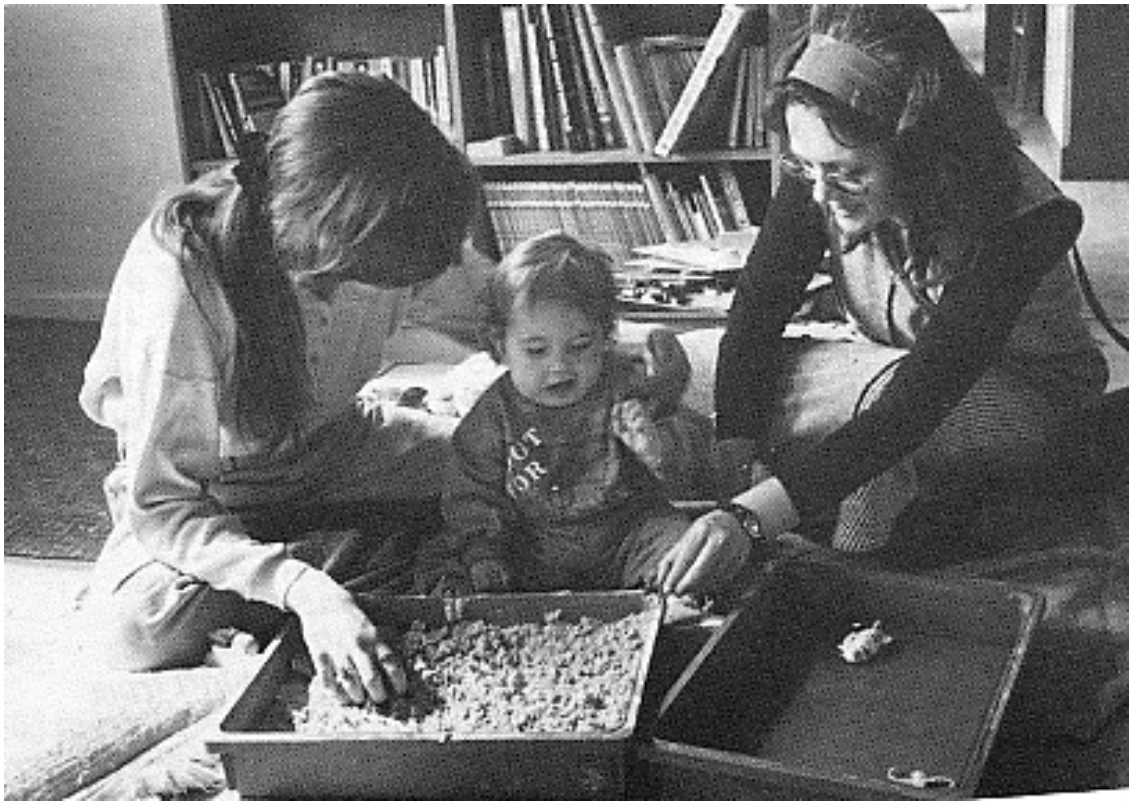


"Boundaries and Space"
Transitional objects ... potential space .. play space
Teaching and learning (and therapy) take place in the overlap of our play areas.

Results of Rehabilitation

In the previous chapters we have looked at the theories and discussions regarding bonding and attachment and considered whether good attachment can be achieved after the first year of life and indeed whether the parent child relationship can be healed in the rehabilitation process.

The following represents the results of rehabilitation at Youth Support House.

For the purposes of evaluation we considered whether each case was 'successful' or 'failed' on the basis of success meaning either that the family was rehabilitated back together and were returned to the community - or in two cases we rated them successful outcomes despite the fact that mother and child were separated.

In these two cases the mothers were both young schoolgirls of 14 years who decided to give up their children for adoption and they were helped to come to terms with this decision which was 'right for them'.

The rehabilitation process is obviously slightly different in quality depending on the prior needs of the families and on their emotional states - some, the more psychologically disturbed, may need more psychotherapy - whereas others, the more deprived, may need more general support and education.

Hence in the evaluation process parents were divided into five categories

Categories of Parental Disturbance

Group 1	Deprived
Group 2	Alcohol / substance abuse
Group 3	Neurotic illness
Group 4	Personality disorder
Group 5	Borderline or psychotic.

Naturally there is some overlap of conditions but parents were placed in the category which produced the biggest influence on their treatment.

Not all definitions were entirely clear cut since when one is dealing with substance abuse - the disturbed behaviour patterns produced by drug use can mimic borderline states on occasion - also one has to consider that the very fact that someone cannot engage in therapy or respond to rehabilitation is sometimes an indicator in itself of a more disordered psyche - hence we can sometimes find ourselves in a 'chicken and egg' situation in trying to be over precise in diagnosis.

Nevertheless some interesting results have emerged from our experience over the last few years at Youth Support House.

In evaluating the effect of rehabilitation on the children - we looked at growth - using centiles of growth as a measure of acceleration or deceleration in growth and developmental quotients as a measure of maturation and comparison with normal developmental levels. Ruth Griffiths scales were used to test the younger children with Stanford Binet mainly being used for the few older children.

These measures of GROWTH and DEVELOPMENT I feel reasonably confident in being accurate.

Other subjective measures were recorded regarding - the child's perceived emotional state - (happy - unhappy) ; and perceived closeness to parent - these were both a five point scale used 'in house' and were entirely subjective - their results have not been included in this description due to the entirely subjective nature of the values - however it is worth noting that the values increased and decreased in tandem with the rates of developmental attainment.

The results describe work with 69 mother / child pairs.

In 12 cases a father was also present but the results for fathers have not been included in the numbers in the tables below - many times paternity was in doubt - sometimes the father was admitted for a shorter period than the mother.

Usually placement depended on the mother and rehabilitation came to an end when an endpoint was reached with mother regardless of the position of father.

To date we have not had a successful outcome with a father who has been included in rehabilitation although we have had an 'estranged' father successfully taking over care of his children after separation from their very disturbed mother.

This is partly due to domestic violence between the couple precluding an intense programme for the father or due to breakdown of the relationship between mother and father and the children staying with mum.

Broadly speaking the outcome of cases was as follows -

MOTHER CHILD PAIRS						
Group	total number	non-redeemable	worked with	succesful	rehabilitated with child	rehabilitated separately
1	23	7				
			16	16	14	2
2	9	4				
			5	5	5	0
3	2	0				
			2	2	1	1
4	21	3				
			18	0	0	0
5	14	5				
			9	0	0	0

Outcome - Mother Child Pairs

In group One - the deprived girls - mainly young teenagers and mothers in their early twenties all of whom had been abused - 23 cases were seen but only 16 could be worked with - the other 7 are classified non-redeemable due to court action removing the children permanently before rehabilitation could take place.

These mothers did well. All our interactions were ultimately successful although , as stated above, two mothers successfully gave up their babies for adoption. The other 16 went on to live independent lives with their children.

Group two were generally slightly older mothers - late twenties early thirties, with one mother of fifty. They were all alcoholic and had dabbled in cannabis and soft drugs. Three had also been hooked on valium.

These parents also did well - again five out of five worked with, recovered sufficiently to be able to parent their children - all needed a prolonged period of therapy and follow up - nine months to one year.

Group 3 - neurotic illness - Two mothers with depression and hysterical illness - one was successful in rehabilitation but required two years residential care and prolonged follow up.

In the other case the child - a boy of seven - was placed successfully in a boarding school - he did well - mother did not wish to engage in treatment.

Group 4 - personality disorder - A more depressing outlook - of 21 pairs three children had already been removed; and of the eighteen worked with - 14 children were removed from the care of their parents and four were recommended to be removed.

These mothers had obvious, marked personality disorders but not amounting to borderline personality disorder which is included in group 5. As stated above - the definition and demarcation is arguable.

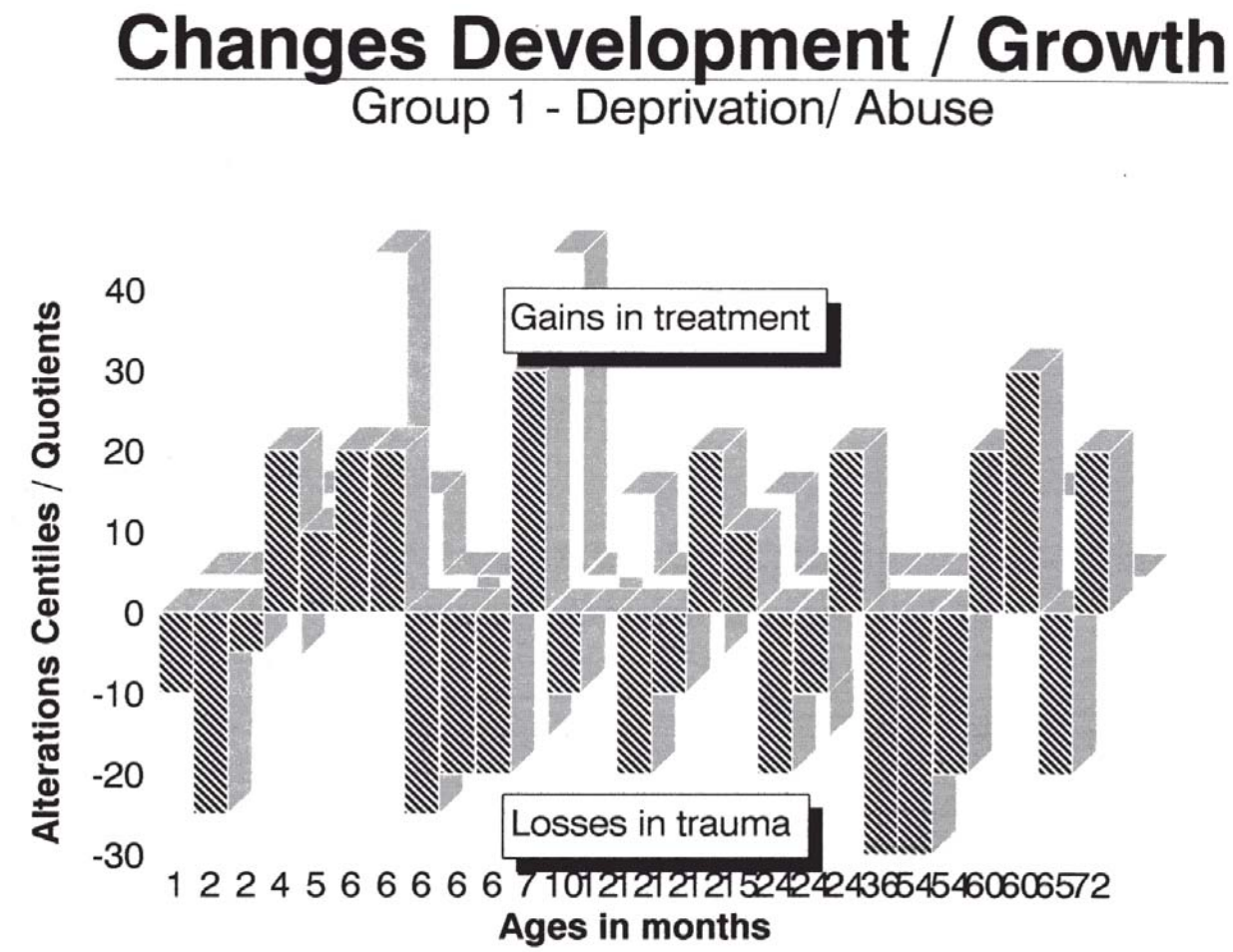
Group 5 - Borderline and psychotic mental states. - This group had the worst prognosis - One child ended up being discharged with a very severely disturbed mother against the wishes of the unit - we had recommended removal and an emergency protection order. Five children had already been removed and all nine cases worked with were unsuccessful in rehabilitation - eight children had to be removed from their parents - one baby had died at birth.

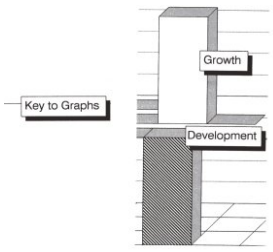
Of the children - one baby was removed at birth and thus was OK - of the other children nine were markedly disturbed and would probably need treatment by a child psychiatrist at a later stage. Two children only were apparently unharmed by the situation - they had a good father figure to whom they eventually transferred.

In this last group - two mothers committed suicide - both had two children one woman had a borderline personality and eating disorder and one was schizophrenic. This group accounted for the entire mortality - two mothers and one baby.

OUTCOME	CHILDREN			CHILDREN			LEFT		ALONE	
	Total	child	child	allready	removed	removal	babies		older children	
Group	child	&mum	alone	removed	in unit	advised	OK	died	OK	disturbed
1	23	14	9	6			1	0	0	3
					2	0	2	0	0	0
2	9	5	4	4			1	0	0	3
					0	0	0	0	0	0
3	2	1	1	0			0	0	0	0
					1	0	0	0	0	1
4	21	4	17	3			0	0	0	0
					14	4	7	0	0	14
5	14	1	13	5			1	0	0	4
					8	1	1	1	2	5
Totals	69	25	44	18	25	5	13	1	2	30

Outcome for Children





Key to graphs

Looking at the situation a little more closely - the following graphs give an indication of the responses to treatment in each group -

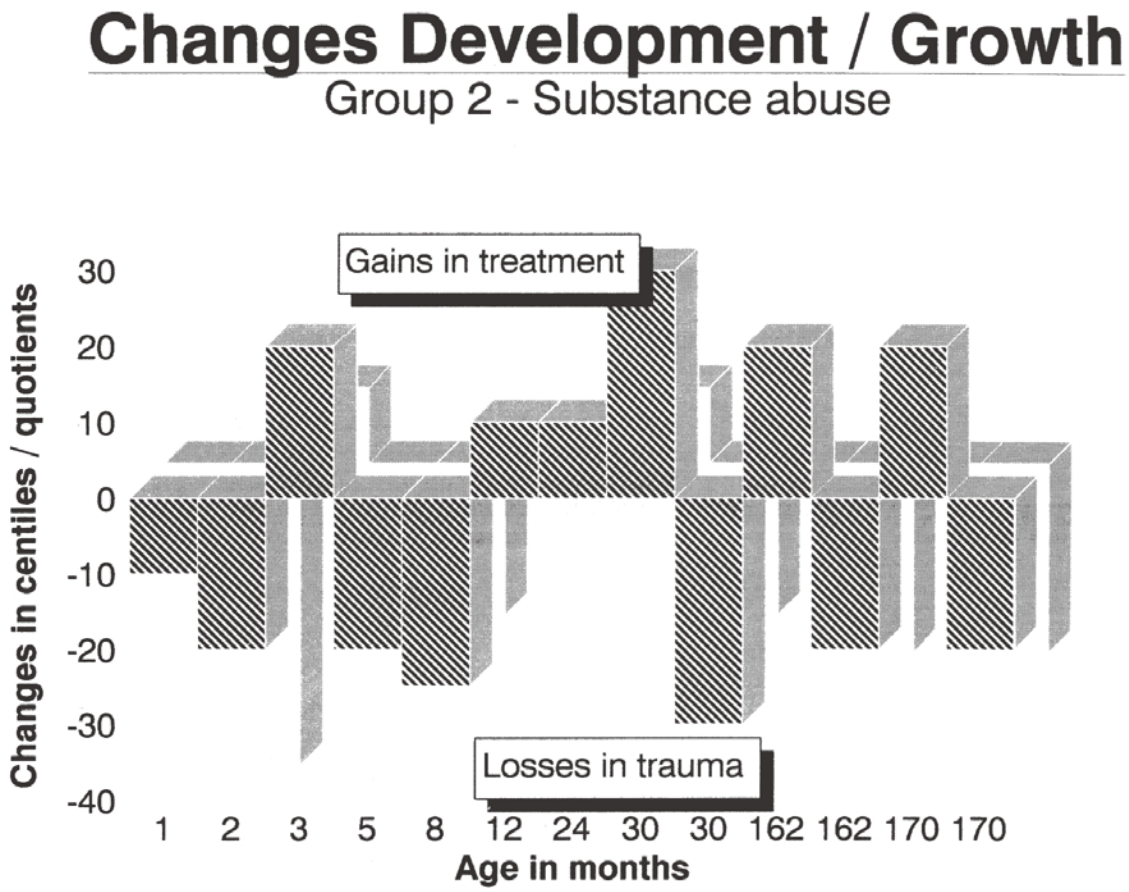
The graphs represent 'episodes' in the interaction between parent and child - each entry relates to an interval when -

- either a traumatic experience - such as separation took place ; or for some other reason the child was deprived of 'good mothering'

- or to a period when rehabilitation took place.

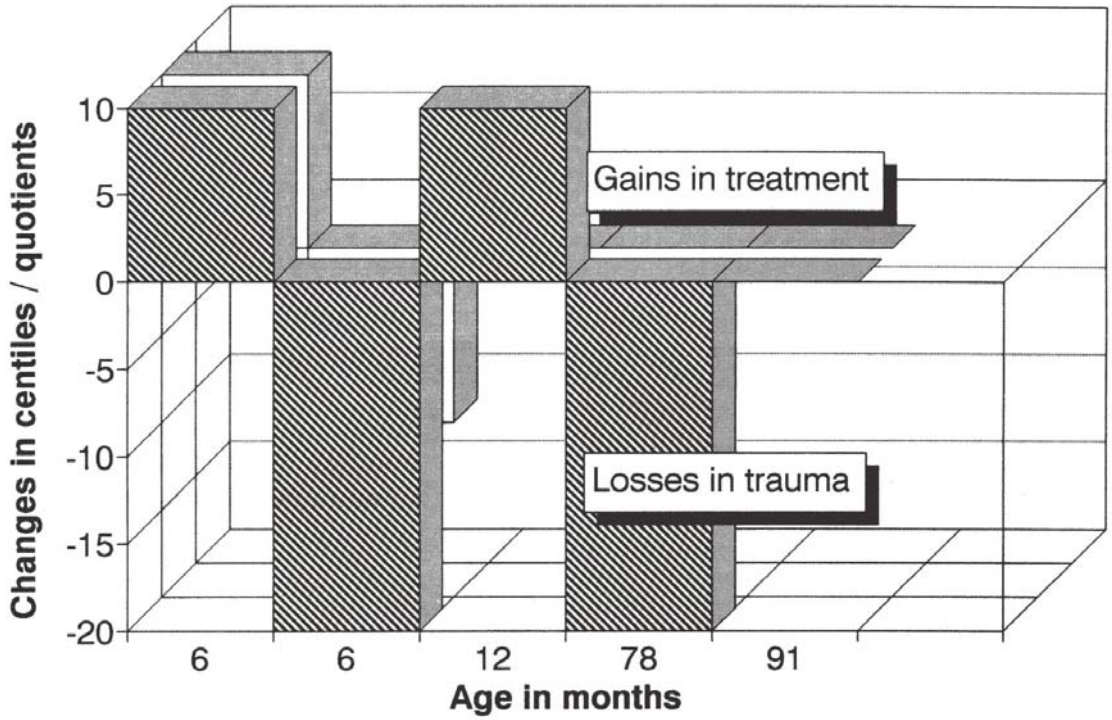
The premise is that children will have problems in the area of growth and development when deprived of their parents, placed in children's homes - as they frequently are before rehabilitation - or during periods when say an alcoholic mother is drinking heavily and is thus 'unavailable' to he child - thus the graphs show 'losses' during periods of trauma - similarly one would surmise that there should be 'gains' during rehabilitation with mother and treatment process -

It is self evident that such changes do occur in groups 1, 2, and 3. - and importantly - these changes occur right up to 13 years of age - the oldest recorded - supporting our discussion that bonding and improved relationship with parents can be modified at later stages of childhood and adolescence.



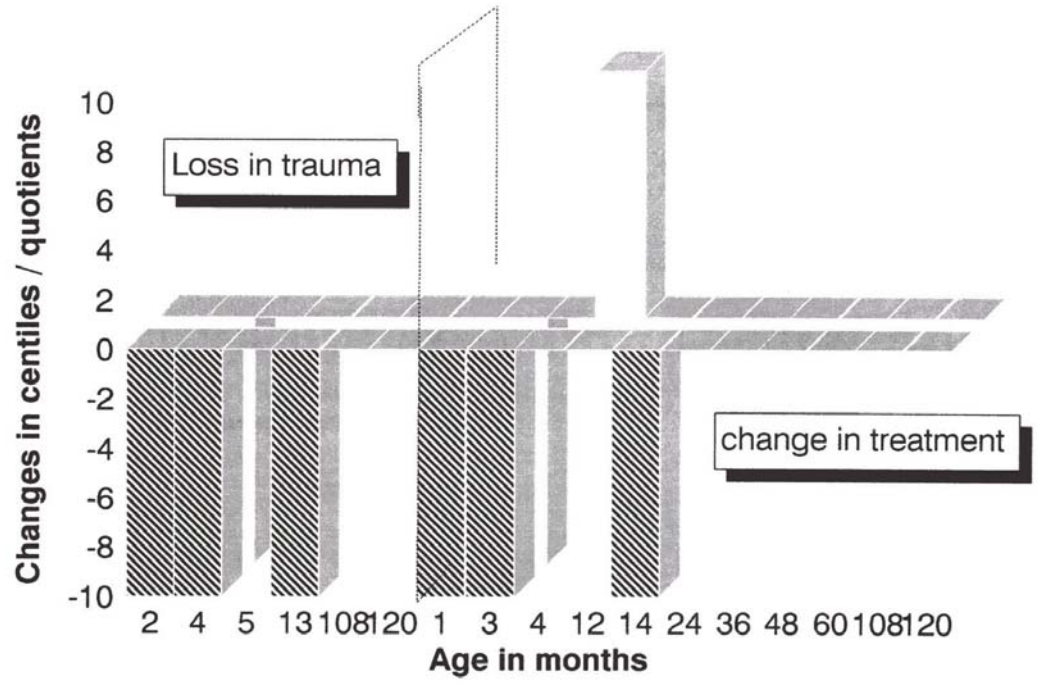
Changes in Growth and Development

Group 3 - Neurotic illness

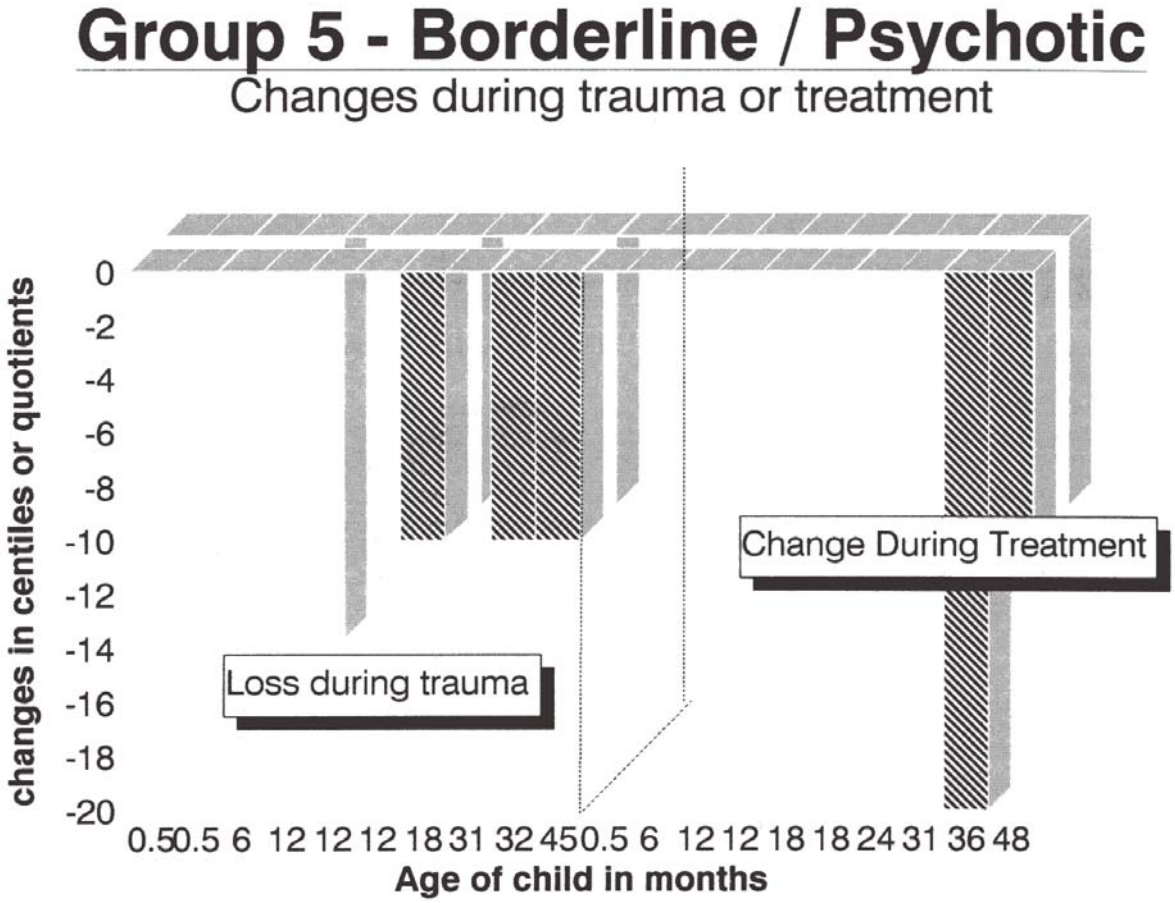


Changes in Growth and Development

Group 4 - Personality Disorder



Unfortunately the same is not true of groups 4 and 5. The graphs clearly show that there is no correlation between changes in growth or development whether treatment is instituted or not - and in group five the whole graph is completely negative ....



Looking at a few children a little more closely -
Some children who had been deprived of their mothers by being taken into children's homes responded in a very marked fashion to the restitution of their mothers within a rehabilitation environment. The table below shows how the emotional deprivation of mother catastrophically affected their developmental attainment and how this was restored to something nearer their real ability levels within a very short space of time. Note also how the child of nearly seven years of age responded to an even greater degree than the 18 month old.

Rehabilitation with parent after separation.

Age at rehabilitation	Time Span	Improvement	Gain
1 yr 6 months	3 months	5 months	3 months
6 yrs 9 months	5 months	14 months	9 months
5 yrs 11 months	5 months	14 months	9 months
5 yrs 11 months	5 months	20 months	15 months

* * * * * * *

Despite her obvious intelligence, Kelly under performed in the testing and at a chronological age of 6 years 9 months demonstrated a mental age of 6 years 10 months thus having a functional IQ of 101.
There has been a major change in Kelly's developmental achievements - now at a chronological age of 7 years 1 month, she is demonstrating a mental age of 8 years and thus a functional IQ of 113. ***Hence in the space of 5 months Kelly has gained in development by 14 months.***

* * * * * * *

Pete was admitted to the residential unit at Youth Support House with his family after having spent the previous eight months in a children's home with his sister and twin brother. ....

There has been a major change in Pete's developmental achievements - now at a chronological age of 6 years 3 months, he is demonstrating a

mental age of 5 years 7months and thus a functional IQ of 88. ***Hence in the space of 5 months Pete has gained in development by 20 months.***

This gives some indication of the degree of emotional disturbance suffered by this child in the period prior to admission to the unit and the beneficial effect of placement - a secure placement coupled with improvement in his mother's coping ability and in the mother/ child relationship.....

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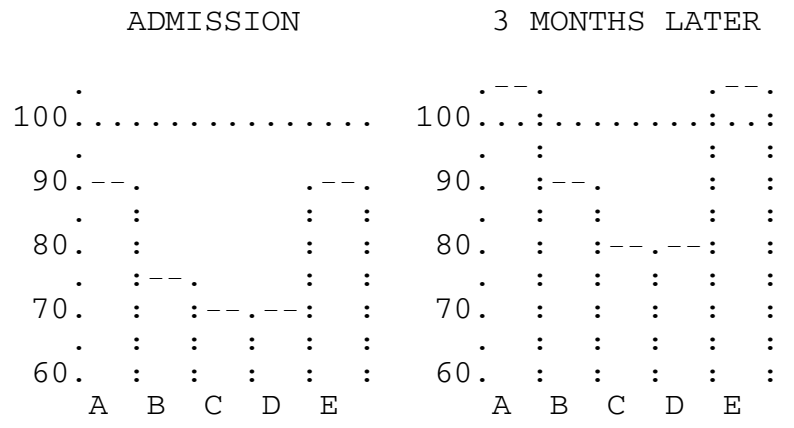
The Carter family had been separated.

Both parents were alcoholic and had marital problems. The twelve year old son was depressed and not coping at school. The baby had been removed to a children's home for failing to thrive.

Their residential care involved an intensive alcohol treatment programme, individual therapy for the adults and older child, couples sessions to work on the marriage and family sessions to work on family roles and relationships.

Remedial education and assessment was provided for the son and the baby's developmental progress monitored. With the family working together in a stable nurturing environment, the child's development scales improved dramatically:-



A-motor B-social C-speech D-coord E-performance

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The abused young adult - Barriers to acceptance in society

Introduction -

Most organisations are required one way or another to have an 'Equal Opportunities' policy - an anti discrimination statement. We are used to considering discrimination on the basis of race, gender, disability and sometimes even social class - however it is my contention that very real areas of discrimination exist on entering adult life for those who have suffered deprivation and abuse as children. There are no 'Equal Opportunities' for an abused teenager .

Let us consider some of the barriers which prevent the abused young adult from becoming a full member of their community; from being an effective parent; from forming their own well functioning family; and from entering society.

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'Fatalistic 'Script'

The first barrier is that trap in our perception of the abuse victim - the cycle of abused becoming abuser. It is as if fate, in the form of a cruel sword of Damocles hangs over the victim ensuring that he or she will in time become a perpetrator.

Many professionals cling , often subconsciously if not overtly to this widely preached view. It is a double edged sword - not only does it condemn the victim and thus render useless any attempt to heal the past and lead a 'normal' life - it also absolves the 'professional' of any need to perform an effective intervention.

TRAP

Abused < ----------> Abuser

Victim < ----------> Perpetrator

On the other hand, the perpetrator is also rendered devoid of blame and responsibility and we are led to collude with the classic misplaced 'blame' felt by the victim.

Just as it is hard for the victim to appreciate that responsibility for cowardly acts of child abuse lie with the adult perpetrator and for the adolescent to realise that recovery is possible - with a full spectra of possibilities. So we, the professionals must believe that an abused child can follow a number of differing life paths - sometimes falling into the harmful 'scripts' of the angry abuser striking back at society or the frightened perpetual 'Victim' role; or the protective and often self effacing 'Carer' role;. The alternative is to be empowered to lead a spontaneous life free of the need to role play.

'Script' Possibilities

Abused < ---------- > Victim

Abused < ---------- > Carer (protector)

Abused < ---------- > Abuser

Abused < ---------- > 'Script free'

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Value System - Own perceptions - 'Yardsticks'

The second barrier lies in the young person's own perception of the world - he has no 'yardstick' no reliable set of values with which to measure himself or his environment.

The abused youngster has been brought up in an environment of pain and 'negative' interactions - negative strokes - or of neglect and withholding of affection. His world to us might seem abnormal and abusive - to him it is 'normal' - it represents the only reality he has ever known - how can he know what is good or bad when he has never known 'good'?.

This 'barrier' affects -

- the way he feels about himself - Self Worth
- the way he judges others - who is safe? - who is good?
- What is a good parent? parenting
- Who is a good partner? - relationships

- Value Systems -

Normality **World / Environment**

Self **Relationships**

Parenting **Behaviour**

Linda - had been abused by her father, she left home at 13 to 'look after' an older man who was violent and abusive. He fathered several children who were similarly abused although Linda tried hard to protect them. When he was jailed - she set up home with another abusive male and when he left her - she 'went looking' for a substitute who could parent her children.

Linda knew that a 'family' consists of man, woman and children - however she had no way of judging the 'male' influence in her life - she had no role model for the 'good male' or the 'good father' she just trusted in fate. She also had no model on which to base her own behaviour.

All the 'fathers' she had known had sought sexual intimacy with her rather than paternal caring. Hence another trap - that despite wanting not to be abused and sexually exploited, her only learned pattern of behaviour was in terms of a sexual 'come on'. Thus the only way she knew of relating - was prone to lead her into further abuse - she was constantly and unwittingly placing herself in danger. And by doing so, she was of course also placing her children in danger - a fact that the social services were not slow to point out.

Hence, by being the compliant victim - Linda actually lost her children - she was thus further abused by the very system which should have been able to protect her.

This is a sorry aftermath of our child protection service which we see over and over and over again - that an abused child is dealt with on the basis of crisis intervention only - removal from immediate danger without on going care and treatment - without any real attempt to 'heal the wounds' - a child growing up often carrying the guilt of their own abuse - who is thus predestined to become further abused.

Thus the teenager has an abusive boyfriend - lacks the personal strengths and self worth to recognise or break from a violent environment. The young adult attempts to create her own 'family' - a substitute for the one

she lost as a child - and the professionals come in again and perpetuate her loss by removing her children.

'Professional abuse?'

Child - abused by family ---------- Child removed.

Adolescent - abusive relationship ----- Unable to break free

Young Adult - recreating family ---------- Children removed

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Lack of resources - empty so cannot give.

If a young person has gone through years of deprivation and abuse, they have never had their own needs met - they are like an empty vessel, deprived of love and affection.

They thus enter adult life , unable to 'give' what they have never received. This 'emptiness' affects their day to day relationships, friendships, work experiences and profoundly influences their sexual relationships and parenting.

The "Needy Child"

Empty Vessel

Never had enough of 'mother'.

Jealous.

Attention seeking.

Insensitive.

Relationships shallow.

Unable to give.

Contact with others tends to be based on what the 'needy child' can get from the other - there is intense competition for attention - since there is not and never was enough mother to go round. Hence it can be easy to see the jealousy, the insensitivity to the needs of others and the 'inability to place others (including their own children's) needs above their own without sometimes appreciating the pain and shallowness of such relationships.

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Insecurity / Unpredictability

There is nothing so abusive for a child than lack of security and unpredictability of your environment. The idea that nothing is predictable - that your parents have no clear set of rules, no way of gauging their behaviour and no boundaries - is emotional abuse in it's worst form. To be 'secure' in knowing you will be treated badly is better than not being able to predict whether you will be abused or not.

Insecurity / Unpredictability

Consequence of action ------- Predictable ---------- Security

Consequence of action ------ Unpredictable -------- Insecurity

Consequence of action -------- Absent ---------- Worthlessness

A young person entering adulthood with no set of values - no way of judging whether they are doing right or wrong is grossly handicapped. Moreover if no one cares whether you do right or wrong - no one cares enough to show you what is right or wrong - then no one cares about you.

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Lack of trust

Abused children have had their most basic trusts - that they placed in their parents - betrayed. They grow up unable to trust anyone and perpetuating that situation by placing what little trust they have in the hands of those who are likely to abuse that trust again - they set themselves up in order

to psychologically reinforce their life position - "I knew nobody could be trusted!"

In reality they reach a position when they cannot even trust themselves - so how can they themselves be trusted? Perhaps to be good parent?

TRUST

Trust ----- Betrayal

Misplaced trust ------- set up for betrayal

Untrusting ------- Untrustworthy

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Poor Object relations

Many of the barriers outlined thus far have their origins in what could be seen as 'poor Object Relations' . An abused child has no consistent image of 'goodness' with which to hold a model of 'the good mother'. The earlier the abuse or deprivation or neglect - the worse this effect. Hence the early analytical concept of the 'good breast' or 'good object' and the opposite concept of the 'bad breast' or 'bad object' , are perceived in the child's psyche as wholly separate. There is no pervading feeling of 'goodness' which can bridge this divide and leave the child with the knowledge that mother still cares and loves him - that the good and bad can be aspects of the whole.

OBJECT RELATIONS

Good Breast ----- Bad Breast

Good Object ----- Bad Object

Perfect S .--p--- l i--- t Imperfect

Adored Hated

An abused child thus may enter adulthood with a very polarised view of the world and use 'splitting' as a psychological defence. In practical terms this means that someone will be perceived as wonderful and 'perfect' when fulfilling their needs and as totally hateful and as the betrayer when not completely compliant. There is no balance and no shades of colour.

Just as such a personality sees others as perfect or completely flawed - so they tend to strive for personal perfection and be as intolerant of imperfection in themselves as they are of acceptance of imperfections in others.

* * * * * * *

Communications

Communication is affected by most of the barriers described above - Abused children and adolescents have been constantly reinforced with the message that family secrets should not be broken - they can't break the silence.

All the self doubts and self deprecation can resurface at adolescence and a great deal of work must be put into measures aimed at improving self worth, assertiveness and self assurance. It is too easy to push a troubled youngster back into being the frightened child.

Communication

Breaking silence

Indirect communication

Acting out

Self Harming

Delinquency

HELP!!!

Frightened children are unable to verbalise their hurt - they act out, scream for attention and by their very use of indirect communication - such as self harming, delinquency and violence often distance themselves from the help they cry out for . It is our job to know how to listen.

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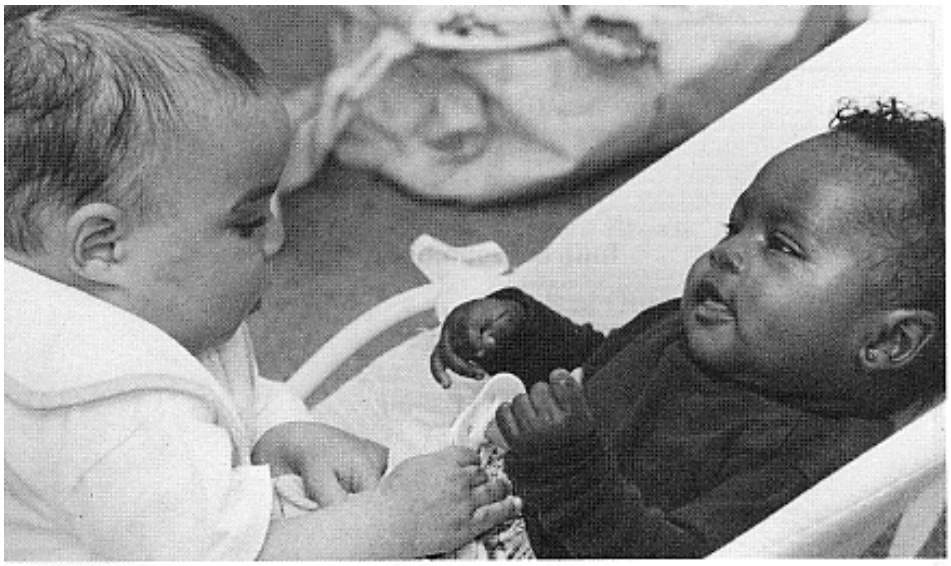
Conclusion

These are but a few examples of the barriers obstructing the young deprived and abused - there are many more which could be cited.

Not least of which is that all pervasive feeling that you have always been a nobody, that you have always been treated as a nobody and that you will never be anybody. It requires society to assume a positive attitude of acceptance without discrimination before such barriers can be breached. We must believe in these young people - so that they can believe in themselves.



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Disordered Family Structures

Boundaries, Enmeshment and Identity

..... In the end she set fire to the place.

I had said that she would sabotage herself - but I drew no solace from that as the children wiped tears across their soot streaked faces with blackened blistered hands -

"Why, Mummy, ... why??".

The air stank of smoke and the sort of acrid, cloying smell that pervades from a wet, smouldering dustbin. It seemed to cling to everything and brought with it a sense of despair - an unhappy but somehow inevitable ending. A shivering, pathetic group that could have been a family, huddling against the melted black plastic bin liners holding their last few posessions.

Had I misjudged the situation?

Had I underestimated her degree of disturbance?

No - not really. I had known how difficult our task would be - but I wanted her to succeed - she deserved our putting in every last effort to reach her - giving her every last chance to respond.

With more resources, more time to work - who knows? But sadly time was not on our side and she knew it.

Unable to face the uncertainty of waiting for the result of the final court hearing, she found a certain security in precipitating the outcome.

She found a way of saying -

"Here you are, you were right all the time. Stop making me jump through hoops for you. I'm not a fit mother, I'm not worth bothering with. Just get on with it and take my kids away".

* * * * * * *

Difficulty of establishing an identity.

If you are unclear about your own personal identity you have no clear boundaries of your psychic space - where does your identity end and another's begin?

You cannot 'bond' with others or with your children if you are symbiotically linked with them. You cannot bond without first separating.

Separation / individuation results in 'this is me'. - Hence 'you are not me' - leading to 'I can be close to you and care for you if I want to'.

Disordered boundaries have long been recognised as symptomatic of a number of 'abuse' situations - particularly when boundaries are ill defined between members of a disorganised family.

This is the classic scenario when sexual abuse may occur - family roles are ill defined, and normal taboos and codes of behaviour are obscured. In such a situation the distinction between having sexual relations with your wife and your daughter - or with your girlfriend and her child is blurred.

In that case it is the family identity which is unclear and individuals are lost within the fused structure. On an individual basis however, the damage to the ego can be quite catastrophic.

How can a child brought up within a disordered fused family mass operate when separated from this - albeit disturbed part of herself? A child 'plucked' from such a situation, without adequate, intensive help, will be forever searching for the missing parts of her 'self'.

Such is Caroline's lot - removed from home at an early age, bereft of love and understanding, she has very little concept of 'self'. Her identity seems one empty void ready to soak up the pathology and behaviour patterns of others like a sponge.

She has a craving need to associate with disturbed individuals who both represent and allow her to acheive some measure of usurped closeness with those original family members whom she 'lost'.

Her misfortune is that her 'lost family' were so harmful to her. A hated father who was violent, drank to excess, mistreated her and rejected her and finally acquired a 'girlfriend' younger than his daughter who he had sex with openly in the family home in front of his children.

A mother who had not one ounce of mothering in her, who rejected Caroline, had several violent relationships resulting in children she could not care for. Who was an alcoholic and drug user and who expected her daughter to care for younger siblings - even after she had four children of her own.

Caroline became torn between being the 'good mother' that she never had - trying in every situation to care for those around her - despite her obvious inability to do so effectively - and being or associating with the 'bad mother' in an attempt to understand her own.

The end result was that rather than become a mother - she in fact became a needy child - in a family which she created herself. Repeated pregnancies resulting in four delightful children - who became her siblings - while the eldest child at six years of age, became 'mother' to them all.

This little mother was quite unable to protect her errant 'child/ mother' from her continuing self destructive relationships. Each 'hurt child', delinquent and disturbed young boy or girl who came within Caroline's sphere were 'absorbed' as part of her deficient ego.

The most damaging personalities however were those where substance abuse and self destructive behaviour was a prominent feature. Caroline completely identified with such disorder - mimicking their behaviour patterns and attempting to almost entirely assume their personalities.

This resulted in Caroline's attending Alcoholics anonymous and 'confessing' to being an alcoholic - when she hardly ever drank - and the most serious event of all - setting fire to her flat in order to identify with her closest 'friend', Dora who had survived an arson attack by her incestuous father. He had tried to kill the family but died himself in the blaze when she disclosed - and so ended - their relationship.

Caroline's first attempt at arson coincided with Dora wishing to break away from her and her second with a final separation. During the first she was on the telephone to Dora throughout the advent of fire-engines and police - having to be forcibly removed from the phone to answer questions. Prior to the second, more serious incident her children remarked - 'We're going to be on television, like Dora'.

A prominent feature of Caroline's behaviour during such episodes is her total absence of appropriate affect. No emotion, no remorse, almost one would say, no involvement. Complete detachment from the consequences of her actions.

But - of course -

..... if you do not know who you are
- how do you know what you are doing?

* * * * * * *

A Conflict of Identity

Assuming another identity, stepping aside and viewing your life from some'where' or some'one' else can be a useful self defence move. Roles are reversed. In a single step you can be absolved from all responsibility for your actions and become the object of the scene rather than the subject

or perpetrator. Meanwhile a 'victim' of a painful situation can become the strong agressor.

Self hatred and debasement can both originate from actual abuse and serve as the source of abusive drive towards others. This mechanism taken to an extreme can explain the seemingly bizarre statements and behaviour of some who have taken abuse to the limit of murder.

"... I was standing in front of the mirror and I could see her reflection. ... Someone stabbed her and I saw the body bleed."

He witnessed the murder in the mirror - the killing and mutilation of the image which represented both the image of the victim and also simultaneously the 'image of self'. This man, from a very early stage, used a split off, voyeuristic view of the world to cope with internal 'psychic' pain.

He had an unnerving way of avoiding my glance, conversation could take on the feeling of communicating with an autistic - no eye contact - until I noticed that he did have contact - with my image in any reflective surface.

At first it used to make me jump .. like that sudden jolt of embarrasment that you feel in a train carriage when you are looking out of the window and the light changes, so that you suddenly find yourself inadvertently staring into the face of the passenger opposite. But there was nothing inadvertent or accidental with him. The stare was predatory, I felt spied on, caught out. I found myself avoiding and eliminating polished surfaces in my consulting room, keeping the curtains slightly drawn to restrict reflections.

It is always difficult when a patient menaces the doctor - there is often some kind of bravado, some sort of 'let's outsmart the Doc' around and a postured testing to see if this is someone who can be trusted or who knows what they are talking about. Most patients have been through the system for a number of years before coming to me - they are hardened, street-wise when it comes to 'therapy' and do not tollerate fools easily. The inexperienced worker can become so much cannon fodder.

I was aware of this, yet I knew the 'counter-transference' emenating to me from this man was scary and threatening. On one level I switched it off so that I could work with him - but on another level I had to be aware - warning signs should be taken note of - this man was as much a danger to

me as a patient with Lassa fever would be if I was an infectious disease consultant. You give them the best of your professional expertise - but you wear a gown and mask.

Self preservation is the number one criterion when working with dangerous patients. I recall a conference where a giant residential worker from Newcastle was asked how he handled a berserk nineteen year old who came at him with a knife - 'Run like hell!'.

Much of the menace in these sideways looks were I felt, directed towards me as a woman. I became his hated and adored mother. His mother had been very close to him, had clung to him as a child as a respite from a violent marriage. His feelings towards her were confused, he felt swamped and unable to separate. It was as if the only way to separate and be an individual was to kill her off.

This is, of course, what normal children do in analytical terms at an early infant stage when they resolve the internal conflict between their good image of mother and bad image. They are allowed to 'attack' the bad mother who survives the assault and can become part of the whole mother again. But if somehow this healthy tussle with mother is interfered with the scenario can change.

One 'scene' which played on his mind and he eventually felt he had to tell me involved a 'mirror scene' and conflict of identity. It had a dream like quality but he insisted it was not a dream but an early memory. He was a baby - probably about one year old and still in nappies. He was lying on a bed being changed by his mother - he knew she was doing something bad to him and as an adult he was connvinced that she molested him in some way.

He said it was weird that he knew this was something which really happened to himself but at the same time he was aware of seeing the scene from outside - as if he was watching it in a mirror. The scene ended with the appearance of a large dark man blotting out the mirror so that he could no longer see, he felt his mother pushed away and the man yelled 'What do you think you're doing to that baby! Don't you dare do that!' He was left feeling bad and somehow guilty.

He grew up 'fused' but ambivalent towards his mother, confused about the boundaries of his personal space and unsure of his identity. He loved and hated his mother while feeling suffocated by her, he feared his violent

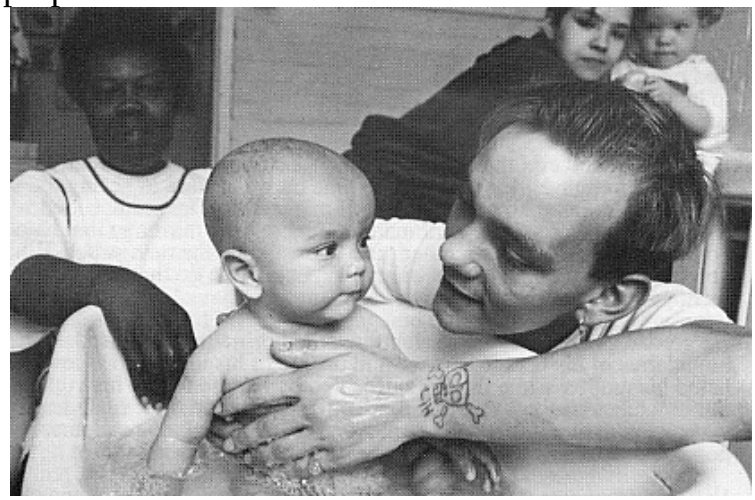
father while somehow needing to identify with him. His sexual identity was a source of conflict and resulted in his involvement in sadomasochistic homosexual affairs with no permanence in any friendships.

Viewing from outside in moments of crisis could account for some of the 'out of body' experiences which occur at times of near death - such as during heart attacks, recovering from major surgery - it is certainly something which is frequently described by children who have suffered brutalising experiences and sexual abuse. They are no longer the victim - they are elsewhere and cannot be hurt.

The mass murderer Nielsen describes how he identified with his murder victims. He kept the bodies next to him in bed, he washed them and dressed them as himself. Earlier he had made himself up to look like a dead body and would look at himself in the mirror, made up to be dead - he said he looked like his dead grandfather - then he became his dead grandfather and ceased to be himself.

So he became … took on the identity of the dead … and the dead took on his identity.

There was no boundary or distinction between murderer and victim - abused and perpetrator



Encounters with Bernhardine - The presentation of Munchausen syndrome in Adolescence.

"He who does not doubt,
Does not investigate.
And he who does not investigate,
Does not perceive.
And he who does not perceive,
Remains in blindness and error."

Al-Ghazali (1058-1111)

It is with this quote that Rutter and Herzov begin "Child and Adolescent Psychiatry". No quote could be more apt as applied to the investigation and diagnosis of 'Munchausen's' syndrome.

My first contact with Munchausen's was when, as a medical student I was coming to the end of a shift in the accident and emergency department at the Royal Free Hospital - an ambulance screeched up, siren wailing and we all waded in to deal with an acute collapse, possible coronary. As I pulled back the clothes to examine this middle aged man, I gasped in horror to see the criss-cross of scars covering his chest and abdomen.

The casualty officer, newly arrived from University College Hospital, came up behind me and, rather unkindly I thought, pulled the oxygen mask from this unfortunate's face and said 'Not you again!' Apparently this fellow had a file a mile thick at UCH and had just been discharged after being confronted with the diagnosis of Munchausen's - he had done the same at several other hospitals and thought he was moving to pastures new.

We eventually, several hours later, managed to eject him - and I went to catch my bus home. Suddenly I became aware of a commotion in the street - A man had collapsed - he had a fit - call an ambulance!

To this day I remember my embarrassment, trying to convince the 'well-meaning public' not to call an ambulance - 'please, there's nothing wrong with him, we've just discharged him!' - their looks were of incredulity and disgust at my lack of compassion.
Later, as a house officer, I was confronted with a female patient - a doctor's wife - who had recurrent unexplained fevers. Her blood cultures

grew bizarre collections derived mainly by rubbing faeces in self inflicted wounds.

The eponym Munchausen's syndrome was applied by Asher (1951) to describe a syndrome characterised by dramatic presentation of physical complaints, pathological lying and wanderings from hospital to hospital. However, one of the most notorious cases 'The Godfather' who had hundreds of admissions was reported as early as 1939. (Stengel).

Asher described three types - acute abdomen, haemorrhagic, and neurological (fits and collapse) but subsequently a plethora of other presentations have come to light with symptomatology frequently mixed. (Bursten 1965, Birch 1951, Chapman 1957, Enoch and Trethowan 1980). The patients have been described as hospital addicts (Barker 1962).

Munchausen's has been classified as a hysterical personality type (DSM III) with depressive features and lack of clear personal identity. Attention seeking behaviour with masochistic tendency resulting from a severely disordered personality. Many patients have been involved with the law in terms of petty theft and litigation against the medical profession is often threatened.

Interestingly, it was a legal issue which delayed the publication of one of the first reports of a mother using her child as an extension of her disordered self. The woman had exhibited Munchausen's for 16 years with admission to ten hospitals, fabricated diabetes in her two year old daughter and poisoned her five year old son with Promethazine to induce neurological symptoms. (Burman and Stevens 1977).

* * * * * * *

> *"... To find a name for this syndrome we sought the family history of Hieronymous Karl Frederich von Munchausen (1720-97).*
>
> *He married Jacobine von Dunten in 1744, but we can find no reference to any children in this marriage. Jacobine died in 1790 and Munchausen married the 17 year old Bernhardine Brun in 1794.*

In 1795 Bernhardine gave birth to Polle, who died a year later. As Bernhardine spent her wedding night dancing with another, the paternity of Polle must be suspect.

We suggest ... such cases should be known as Polle syndrome - a child of a Munchausen whose life expectancy is liable to be short..."

* * * * * * *

Of course this terminology - Munchausen, Polle ... was applied to the syndrome in a rather tongue in cheek manner and the term Polle's syndrome is no longer used; however it did convey some of the flavour of the Munchausen situation - that of drama, fiction, of never quite knowing what is true and what is not.

It was in the previous week that Meadow published his first case reports and coined the term 'Munchausen by proxy' (Meadow 1977) - which formed the catalyst for collating reports which had appeared under varying headings. In the previous year six cases of poisonings in disturbed families were reported (Rogers 1976) and bizarre types of child abuse were understood to form part of this worrying illness.

The most common presenting symptoms have been apnoea attacks when a baby stops breathing, and fits but fabricated illnesses have included Cushing's syndrome, bleeding from any orifice, repeated infections, vomiting, deafness. (Lee 1979; Kurlandsky 1979; Witt 1981; Hodge 1982; Waller 1983: Samuels and Southall 1992)

My own experience has also involved broken glass added to a feeding bottle and ground tablets in infant food, salt induced hypernatraemic fits cause by table salt being added to the baby's bottle, and suffocation with a pillow.

The mother or rarely father (Makar 1990) will appear close to the child, appear caring and co-operative with medical staff, be extremely clever and resourceful in deceit and put on a show of wounded disbelief rising to overt threats of litigation when challenged. It is vitally important that staff support each other in this difficult diagnosis and keep the welfare of the child paramount when facing their own incredulity and wish to back off from what can be a very unpleasant situation.

"The importance of maintaining a high degree of suspicion related to the warning signals cannot be overrated"
(Mrazek and Mrazek 1991)

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A number of authors have reported family disturbance whereby several siblings have been abused (Black 1981), some have died in unexplained circumstances, and Meadow has collated sibling mortality and morbidity (Meadow 1990; Bools, Neale and Meadow 1992). However for some time adult Munchausen's and childhood 'Polle' were described as if discreet entities.

It has been recognised that Polle's mother may have had Munchausen herself but the concept of a continuum in Munchausen is important and has been overlooked too long. We need to look at the Munchausen family dynamics and particularly - what happens to the adolescent?

Young people growing up in an atmosphere of deceit are certainly prone to develop Munchausen's themselves and a number of authors have reported that children assist their mothers in deception. These unfortunate children are abused by their parents, abused by their doctors in over-investigation and inappropriate treatment - and finally abuse themselves.

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Case Histories -

The following two cases illustrate a Munchausen family syndrome with **presentation in adolescence.**

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Case 1 - Kelly

Kelly presented as a pregnant 14 year old who at the time had 'strong ulterior motives' for becoming pregnant. Pregnancy was in doubt until the results of an ultrasound scan was known since she had a 'pseudocyesis' two months before. She was a difficult, forceful girl who was attention seeking and disruptive wherever she went.

The family were under threat of legal action for school non attendance and Kelly thought her pregnancy would bring that to an end. Kelly gave a

bizarre account of her pregnancy which became more elaborate each time I saw her and her mother forcefully added her embellishments to the story.
My suspicions were raised and on investigating the family history and collating all available information the following picture arose -

Birth - Described as a difficult baby - 'mother had to fight hard to keep her alive' - {It is amazing how often one hears this story of the valiant Munchausen mother fighting for the survival of her poor weak infant - when the reality is that she is actually hastening it's demise.}

Aged 8 - Admitted to hospital for rectal bleeding - No abnormality discovered (NAD)
Later that year ear nose and throat (ENT) investigations were also negative.

9 yrs Audiology and ENT again - NAD
School complained regarding non attendance - where upon complaints were made against the school - mother alleged that classroom noise caused her deafness.

10yrs - welfare officer reports "for the past year I have been plagued by complaints of one medical disorder after another from this child". Mother insisted on keeping her off school.

11yrs earaches, ENT, hearing loss, gastric ulcers (none substantiated)

12 yrs - subject of CARE ORDER but left at home! - workers could not cope with mother.

13 yrs rectal bleeding, psychiatric referral, maladjusted school recommended - doctor states "Her mother's influence is certainly strong but can only be described as malignant"

All special help or attempts to remove girl or educate her met with stubborn opposition and more symptomatology. Her papers on education took nearly two years to complete "due to multiple problems within the family"

Family used multiple agencies and set one agency against another, caused dissension and invoked various complaints procedures. A psychologist stated "..Lengthy and widespread support has reinforced rather than

modified mother's behaviour with consequent damage to the children who are constantly encouraged to view themselves as ill when this is not the case."

14 yrs - three important placements fell through due to family manipulation. Kelly was being denied appropriate help. She has so far attended at least six hospitals.

Kelly reported to be pregnant - not true

Pregnant 'again' - this time true. Varying stories regarding conception.

'Boyfriend' Mark said to be living in house with mother and said to have made both sisters pregnant. Later said to have got pregnant at a party and both sisters had sex and got pregnant with same boy on same night.

Kelly reports she has a hole in the heart, deafness and gastric ulcers (not true).

15yrs - baby born - very demanding of medical attention but at same time refuting advice - took own discharge from hospital but then kept calling out doctor.

16yrs - during first year baby frequently at doctor or clinic - Several minor injuries and infections, moved flat three times, Seen in accident and emergency at 18 months - cut face, 19 months, cut mouth, 20 months fell onto glass cut face again.

17 yrs baby nearly two - grandmother is accusing Kelly of abusing child - child has attended four hospitals. Social worker has closed case.

18yrs flat vandalised, boyfriend Mark in prison, family moved away and untraceable.

Presumably the family did not delay long in presenting elsewhere at some other hospital in some other part of London - they had changed name at least thre times before - hopefully someone would put two and two together and protect the child.

Family History -

Mother -

Mother was described as a very manipulative lady "her one delight is to fight authority whenever possible". She is wheelchair bound and can sometimes use crutches - but when I visited by the back door I found her walking normally and others reported hearing her run into the chair when the door bell rang.

Constantly litigating, seeking compensation or threatening legal action.

Decided to make a complaint regarding under age sex but the alleged perpetrator was openly living in her home and frequently seen pushing her wheelchair in public.

Father -

A -real father left early on and divorced when Kelly was 5 years old. Said to be alcoholic and violent.

B- Mother's second husband apparently lived with her before Kelly's birth and left when she was 12.

Said to be a very violent man and to have thrown a fire bomb through the window of the previous flat.

Two of the family's apartments have been burned out and it is generally thought that this was self inflicted by mother or Kelly with father blamed.

This man and a friend of his are also accused of sexual abuse of Kelly and her sister but there is no evidence to support this claim.

C- Mother has now established a relationship with a third man who she intends to move in with. He is the father of another pregnant teenager whose family background is similarly disturbed and enmeshed.

Brother - three years her junior.

As baby had 'failure to thrive' and continued to have weight loss, insomnia, enuresis, psychological problems (aged 10) fainting attacks and fits (aged 12).
None of these diagnoses were substantiated.

Sister - one year older.

Multiple illnesses, ran away.

At age 11 started to swallow glass, ball bearings and stones. She was referred for special schooling but the mother obstructed placement and like Kelly she also was placed on a care order which was never implemented due to mother's intimidating authority.

Aged 14 - Pretended to have a grumbling appendix.

Reported false pregnancy at age 15yrs, reported to have a termination of pregnancy at 15 (untrue), complained of sexual abuse - not substantiated.

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This family are illustrative of a number of features - falsification of a number of illnesses, use of many hospitals and many agencies to evade detection, frequent changes of address for the same reason. An enmeshed, disordered family with blurred interpersonal boundaries and transmission of Munchausen syndrome through three generations.

The reporting of illness and disastrous events is more than tinged with drama and excitement - the attention of many agencies is gained by exaggeration but they are not allowed to get close enough to see what is really happening.

Many authors have commented on the need for professionals to work together in confronting Munchausen (Black et al 1991) and in family work this is of paramount importance. It is also important to realise that Munchausen is not only a 'medical' diagnosis.

The Munchausen family with it's 'hysterical personality' traits 'uses' the medical profession to gain attention for themselves or through their children - but it also 'uses' social services or police in the same way - by fabricating events and alleged abuses - for example, the fires caused by the family above, the reports of rape and sexual abuse.

The legal system is also 'used' in making complaints which while serving to set up a smoke screen - also keep everyone dancing to the family's tune.

Just as it is commonly remarked that Munchausen by proxy mothers have a little knowledge of medical matters (the ward clerk or a failed nursing student) so I believe do some families have a little knowledge of the other areas of involvement - such as the social services or the law.

In this syndrome the old adage -

..... 'A little knowledge is a dangerous thing'

could not be more true.

The second case exemplifies multi-agency involvement and the 'use' of legal framework to the families own ends.

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Case 2 - Mona -

Presented as teenage mother

Birth Said to have been difficult baby - (again mother had to *work hard to keep this child alive*.). Behaviour problems as a young child.

Aged 2 Father left home.

Aged 6 all contact with father ceased. Very acrimonious time - mother litigating against father. Many rows and mother screaming abuse.

Aged 10 her twin sisters Daniella and Shirley ran away from home at age 16.

Aged 13 planning to run away. menarche.

Aged 14 Abdominal pain - appendicectomy (doubt expressed as to need for operation ?fabricated) - in hospital six months!

Attended four hospitals. Diagnoses were:-

Appendix; Wound infection; 'Adhesions'; Wound infection again; Urinary retention; Intermittent catheterisation; Suprapubic catheter; Intermittent catheterisation again - Left with 'paralysed bladder' and permanently unable to pass urine unaided.

Specialist unit - refused to learn to catheterise, disruptive ... threatened to run away, ... alleged mother hit her.

Distrusted staff at first hospital who had worried about 'behavioural' component to urinary retention etc. and had reported concerns that *Mona had been interfering with her dressings*. Thought that two wound infections were self induced.

Consultant reports that 16 year old sister Janice has been extensively investigated for dementia. Janice needs lot of care and supervision - now being referred to another special unit for neuropsychiatric assessment - said to be psychogenic.

Staff felt that mothers battle over access and money after marriage break-up had some bearing on Janice's psychogenic dementia.

Mona sent to two other hospitals and child psychiatry.

Would not let her mother in room when catheterised - behaviour thought to be 'strange' towards her mother.

Mother reported to be very needy woman who has a great deal of stress and is very demanding of attention. Got in touch with a large number of agencies and staff and with her solicitor.

Aged 16 disclosed sexual abuse - with Mother's boyfriend since age 12. Oral sex and full intercourse - pregnant by him and had an abortion (she has not had a termination of pregnancy - this is fabricated).

Accused mother of hitting her and screaming at her. Investigations found no trace of boyfriend or man at the home.

Next day - regressed and self harming said she had been hit, had black eye and that he had sex with her again after the termination and she had severe abdominal pain. Hysterical when questioned. When social worker arrived at house she found Mona was being restrained from jumping out of a window.

Two days later taken to hospital by sister Daniella after overdose of 22 Nurofen. Ran out of Accident & Emergency department - police brought her back then she refused to go home.

When home on a visit a month later - secreted cutlery to protect herself from 'Gordon' and anxious about ***a pillow being used to suffocate her.***

Severely scarred shoulders from 'cutting' herself.

Mother claiming compensation for hospital mismanagement and for medical incompetence in 'appendix' complications.

Mona involved college counsellor, District social services, Samaritans, a voluntary agency, Childline, NSPCC, Hospital social services, Psychiatrist and her teachers - all were told a slightly different story and different dates of her pregnancy and termination.

Mother was interviewed at the police station with Daniella present - both assumed that the allegations related to abuse by Mother - but when told that it was sexual abuse mother became distressed, said her other daughter Janice had been abused by a local man. She put her head in her arms and started sobbing - but when lifted her head, her eyes were dry.

Demanded to know who was accused - said that if she was being accused - 'she was not like that'. Said Mona had been a very difficult baby. Started telling history but Daniella said she did not have to go into that.

Mona screams at mother and called her a lesbian.

Neither mother or Daniella expressed any concern for Mona or asked how she was. Daniella was 23 by this time and a police woman working in child protection office. (The potential havoc which could be wreaked from this 'power base' is unthinkable)

Mona believes herself to be mad. Social worker concerned that despite fabrications Mona probably has been abused, perhaps by mother and that sisters may also have been. Remarked that Janice and Daniella dress in a very sexualised fashion.

Mona stayed in hospital 2 months and arrangements made for her to attend college from hospital. Abuse never substantiated.

Referred to another psychiatrist because district nurses having to visit twice each day for catheterisation. Meanwhile the hospital reported confidentially that Mona has no problem passing urine (and never has).

Aged 17 seeing two separate new psychiatrists regarding relationships, trust, obsessional cleanliness.

Pregnant (father of baby is policeman friend of Daniella)

Baby born at 31 weeks gestation 1.67 Kgs by Caesarean Section. - transferred to specialist unit.

Obstetrician concerned that Mona had not been forthcoming regarding details about herself or her circumstances and at times she was deliberately obstructing their efforts to give the best possible care.

Transferred to another hospital at 12 days - home on 14 day. Readmitted at three weeks- said baby had diarrhoea and vomiting -

Said that baby could not breathe and was having apnoea attacks - given alarm. 2 days later apnoea. Baby fine in hospital.

4 weeks - baby readmitted with coughing spasms.
Two days later diagnosed as bronchiolitis.
Investigation of baby's apnoea attacks thought to be due to choking on milk.

5 months - still in hospital - Staff not able to discharge the baby who continues to have multiple minor problems conjunctivitis, cough, hospital expressing concern for baby - Mona scribbling out and altering medical and nursing notes.

Baby's cough continues but remains well thriving and gaining weight in hospital. Still wearing alarm - for mother rather than baby.

6 months - Mona hysterical, overdosed and threatened to cut herself with razor blade.

Does not want to be discharged from hospital. Three consultants (paediatrician, psychiatrist and child psychiatrist) recommend Emergency Protection order. - advice not taken.

Admitted to residential unit for assessment and treatment but managed to get herself and baby admitted to three separate hospitals in the space of

five days - noted to pinch baby, fabricate apnoea, fabricate cough, drop her down steps.

Mother threatened unit with solicitor - tapes conversation with staff. Gives impression she is a solicitor herself but is only a server of court papers.

Daniella reports false allegations to Health authority to discredit the unit.

Daniella very angry at unit reports and says consultants know nothing about child abuse - says that doctors have not believed Mona's reports of baby's apnoea - but Mona 'saved her life'. Reaction concerning in itself.

Baby has been in hospital the whole of her short life.

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Mona's family showed many similar features to Kelly's. Again a three generation transmission. In this case the family threat to the involved professionals and their use of the legal system precluded Mona from receiving appropriate help as a teenager in distress and also aimed to preclude the protection of her child.

Discussion -

The psychological aspects of Munchausen's render adolescents particularly vulnerable. Here we have a syndrome where there is an unclear definition of 'self' - something which all teenagers struggle with and which is particularly difficult for the pregnant teen. Just as the Munchausen by proxy mother over identifies with her child - so the young mother can subconsciously desire motherhood in order to define her identity through her pregnancy.

Once that child is born - the only role model is that of the abusing Munchausen mother - so you please mother by being sick and identify and so understand mother by making your own child sick also. At the same time the fear grows that mother might abuse, kill or take away your baby - something which Mona was terrified of.
This same fear may lead some girls to terminate pregnancies - the ambivalence towards the child is also seen as ambivalence towards the pregnancy. Hence the stories of pregnancies, false pregnancies,

terminations real and unreal. I have known of two disturbed girls who tried to end their pregnancies by inserting foreign bodies into their cervix and this has been reported elsewhere (Goss McDougall 1992).

Certainly the teenagers mentioned here were abused physically and emotionally and deserve and require help to cope with that. Mona was fairly certainly abused sexually also, even though she expressed her dilemma in a way which made it blend in with her fabrications. We are probably missing a number of cases of sexual abuse in these families where the boundary disturbance would lend itself to sexual taboos being broken.

The hysterical aspect of this illness also makes it hard to assess and treat. There are a number of cases where hysterical personality and abuse coexist leading to self abuse, cutting, overdosing without the connotations of full Munchausen.

I would argue that Munchausen in the adolescent can be seen as a perfect example of the abuse victim who is destined to becoming an abuser - but that if identified in the teenage mother, can be treated with support and help to overcome her own history of abuse.

I am reminded that Polle's mother was actually a teenager - and we would do well to be alert to the cries for help of our Bernhardines. This is not a case for condemnation, but compassion and understanding. However such help can only be delivered in the context of a court order to protect the adolescent from family interference and sabotage of the treatment programme - and to protect the professional from spurious litigation.

Symbiosis
Who's going to School?

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"Are you my sister, Mummy?" Study of school age pregnancy. 2nd edition 1992 £10.00

"Retracing the Echoes" Children of the Russian revolution - Emotional aspects of growing up. £ 3.95

"**Inner Worlds and Outer Challenges"** Development of the personality and assaults of emotional environment £5.

"Putting Down Strays" - life in Italy from late 19th century to the second world war. Laura Busini- Birch £4.75

"Mother or Child?" Tape slide presentation

Journal - Back copies Journal of Adolescent Health and Welfare Back copies - (1988-1994) £ 4.00 each

Reports, Articles and Reprints - £3.50 each.

1.1 "Schoolgirl Pregnancy".overview and medical aspects.

1.2 "Teenage sexuality and the Media"

1.3 "Schoolgirl pregnancy - a culture of poverty"

1.4 "That old Black Magic? - Sexual belief systems.

1.5 "Schoolage Pregnancy, the International scene"

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2.2 Sports Medicine - "The Training stresses for children and Young People" "Diet and Preparing for the Marathon"

2.3 "Healing abuse - Working with family that is not there".

2.4 "HIV infection - AIDS and the Young" conf report.

2.5 "Providing staff support in child abuse procedures".

2.6 "Emotional Abuse - The hidden scars"

2.7 "Working with families - how not to perpetuate the abuse"

2.8 "Reflections-Emotional development,origin of personality"

2.9 "The invisible woman - the hysterical personality"

2.10 "Fear is the key - the depressed adolescent"

2.12 "One Track Minds - obsessive part of our personalities"

2.11 "Divided loyalties - the schizoid teenager".

Theses

These are avilable in limited supply and usually require two weeks delivery time.

'Schoolgirl pregnancy in Camberwell' - A population study of schoolgirl pregnancy, motherhood and two year follow up. London University MD thesis, January 1986 - soft copies £50 - loan £15 for one month.

"A Study of Self Esteem measurement in Schoolgirl Pregnancy" soft copies £15 - loan £5 for one month.