Youth Support - Professional Training

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"Healing abuse - Working with the family that is not there"

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Introduction -

The Philosphy of Youth Support House -

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 and dance/ movement therapy are obvious examples - but just as an activity can be used therapeuticaly in such diciplines, so everyday activities can be a focus of therapy in a unit such as Youth Support.

Our everyday management of residents therefore does not involve either sanctions or negative reinforcement - we use only rewards and positive reinforcement. This forms part of our behavioural programme and intervention is planned along these lines.

Unacceptable behaviour is dealt with by witholding reward - not by any form of punishment. In a recurrent or severe case a written warning will be issued and a copy sent to the referring agency. If the patient does not respond to such measures and their behaviour is a danger to themselves and others - they may be asked to leave the unit.

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

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 cooperation 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.**

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patient <---------------> relative

     | | | transference | | |

Patient <---------------> therapist
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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 ie listening to only one half of the story can lead to pitfalls in interpretation.

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 unable to ever 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 parallelled 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 centered 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'.

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 maintining 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 young 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 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.

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**

In assessing the family functioning and teenagers 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**' - ie 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 existant 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 - (cf 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.

THe boundary issue is seen to operate very graphically 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.

Triangulations and Collusions

In many of our families 'straight' communication betweeen family members has been difficult. The young person has often been used as a pawn in communication issues. Patterns may involve triangulations 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'**.

The technique of **cross confrontation** is of value in family therapy - ie 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 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 discosure 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.