Youth Support - Professional Training

Reprints - Series Two No 7

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

Dr Diana Birch
Director Youth Support

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

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

Dr Diana Birch
Director Youth Support

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

"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 boundaryless 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.

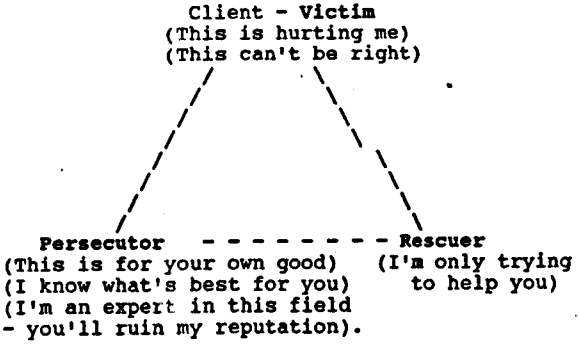
A classic 'family view' of the triangle in action is provided by the alcoholic family. A common scenario might be - drunken husband (Persecutor) comes in late and berates wife (Victim) for not having dinner ready; she (now Persecutor) then turns on him (Now Victim) for being drunk again ; he then throws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



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.

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?

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.

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 covert disgust at circumstances 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?

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.