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When is it serious enough? The protection of children of parents with a mental health problem, tough decisions and avoiding a 'martyred' child

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Abstract

This paper outlines some of the very real emotional challenges and decisions faced by mental health workers with clients who, through no fault of their own, are failing to meet the needs of their children. In particular, it focuses on the effects of long term emotional abuse and neglect due to parental mental health issues and includes discussion of some difficult concepts such as 'good enough' parenting, and what constitutes harm. The paper proposes that it is very difficult for adult mental health workers to hold in tension the needs of the adult client and the needs of their children, when sometimes these are at odds with each other. It ultimately argues for a change in service culture where the ethical and moral nature of these decisions is discussed and debated, rather than what could be seen to be an emerging culture of fear, based on recent critical incidents and unwanted media attention.

Keywords
parenting, children, child protection, family intervention

Introduction

Over the past ten years, there have been significant changes to the role of mental health professionals in relation to possible child abuse and neglect. With increasing media attention to child deaths where a parent has a mental health problem, as well as legislative changes in a number of states introducing greater responsibilities for health professionals, mental health professionals are increasingly being confronted with difficult decisions around 'adequate' parenting and their legal and ethical responsibilities.

One of the most difficult issues mental health workers face is the situation where parents are attempting to parent adequately, but their care is still not 'good enough'. Often the harm caused to children in these situations is not the result of any maliciousness on the part of the parent, but rather due to their own trauma issues, as well as current mental health problems. While parents need to be given the chance to improve their parenting ability and level of care, it can be too easy to put off tough decisions about capacity to change because the parent is trying to change.

When is it too harmful? How long is too long? Kempe (in Jones, 1988:418) comments '...we should stress that when we say a family is untreatable, we do not mean that the parents do not deserve treatment. What we mean is that the child should not be used as the instrument of treatment ... there must be a more civilised way

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of dealing with incurable families than providing a martyred child'.

This paper considers some of the issues involved in waiting for emotionally abusive and neglectful situations to improve when a child is being harmed on some level.

Parental history and issues

In many families that come to the attention of child protection authorities, the childhood histories of the parents can be even more traumatic than the situations being replicated with their children. So many times, the parent's experiences during their own childhood were not acceptable. Many of the parents have also had large hurdles and obstacles to face in their adult lives, that they have survived with tenacity and creativity. Their own issues need time and healing, yet they have come to the attention of child protection authorities because these issues are impacting on the adequacy of care they are providing their children. There appears to be a high correlation between childhood abuse and later mental health problems, with patients of the mental health system often having a complex trauma history.

The proposal of this paper is that it is especially hard for workers to act upon the effects for children when the harm is not intended by the parents and they are making some attempts to change. It is also suggested that the effects of some forms of abuse are actually harder to see – such as the less direct issues of neglect and emotional abuse, sometimes due also to exposure to domestic violence.

Of the 159,643 child protection reports received in NSW during 2001/2002, concerns about adult carer issues accounted for 45.5%. In these situations, Scott states (2002:416) that 'many would argue that it is harm rather than parental intent that matters. Children of parents with a substance dependence, serious mental illness or intellectual disability - the groups that now constitute a majority of child protection cases in western societies such as Australia - are at risk of serious harm, but few are harmed as a result of an intent to injure or intent to use violence.' These parents, when approached by child protection authorities are often surprised or somewhat unaware of the effects of their own issues on their children. They often express the desire to change to meet their children's needs, and many can and do. But for some, this is either unrealistic or they are unwilling to make the necessary changes.

These changes can be all the harder as the parent often is not aware that their behaviour was not 'good enough' and so assisting them to understand what is 'good enough' and coming up with concrete goals presents a challenge for the worker. When the mental health problems are ongoing and long term, for some parents this may mean that no amount of support is enough to improve the standard of care the child is receiving.

'Seeing double'

For adult mental health workers, working with a vulnerable and marginalised group of the population presents so many challenges and takes so much energy and focus, that it can be almost impossible for the worker to be asked to notice the ramifications of the person's illness on others. There are increasing expectations that mental health workers will be able to not only treat and care for the person, but also notice and indeed assess the needs of others around them, such as partners and children, and all of this in an already stretched and over worked sector. Fleck Henderson (2000) used the term 'seeing double' to describe what workers need to be able to do. They need to be able to hold and see, simultaneously, the needs of the adult client and their child. This involves being able to have empathy and concern for the adult, but also being able to recognise the effects on the child and advocate for them as the most vulnerable member of the family.

The question has to be asked whether it is possible to 'see double'? It has been the author's experience that even in a child focussed service, where two workers are allocated to the same family - one working with the adult, one working with the child/children - the difficulties of 'seeing double' are played out. One worker will say 'this is not good enough, things are not changing fast enough, the child is suffering...' and the other worker will counter 'but the parent is trying… give them time… you can't take away their motivation to change'. The first worker will reply 'but the child needs this to change now,

they cannot keep waiting'. Advocacy for a client is a natural phenomenon; taking on some of their perspective is to be expected. But when this is happening for two workers, how much harder is it for a sole worker, who is trying to balance the tensions of the differing needs of both the adult and the child within themselves.

Hence, seeing double is an even bigger ask for those whose primary role is to advocate for oppressed and disadvantaged adults who make up much of the population of people with mental health problems. Yet, this is what mandatory reporting laws, many policies, and indeed public and media pressure require them to do - to be, at times, able to prioritise the needs of the child for protection above the needs of the adult client. While this may seem straightforward to those who come from a child focus, anyone who has worked alongside an adult experiencing these difficulties, advocating for them, hearing their story, will tell you of the incredible challenge this becomes. Even noticing and recognising the risk and harm to the child becomes difficult when you are focussed on what can be the all consuming needs of the adult client. Killen (1996) points out that whilst it is painful to witness a child's harm and abuse, it is equally painful to understand and accept the parent's losses and their grief for the life that never materialised, the help to grow up that they never had when they needed it – and the experience of inadequacy, pain and hopelessness they are left with.

Both Munro (1999) and Killen (1996) note these types of tensions lead to workers at times only paying attention to the parts of the knowledge of a family that support their view:

Such over identification leads to a tendency to minimize the abuse and neglect and what it costs the children in terms of daily suffering as well as the consequences. We develop a distorted picture of the children, we see them as healthier and stronger than they are and attribute to them qualities that we like to see in them. Meanwhile the children use their resources mainly for survival and not for development and maturation. (Killen, 1996:793)

Killen suggests that this over identification represents our own lack of ability to face our negative feelings towards the adult, to face our anger at the hurt they have caused the child and to even acknowledge the hurt and pain experienced by the child. This over identification makes it almost impossible for us to use professional authority and a failure to report that a child is at risk often results. There are also valid concerns workers hold about whether a foster care situation will be any better, following the numerous high profile reports that have shown child abuse in care (for example, see Cashmore, 1994).

Missing the effects on children

Because adults are usually more experienced at getting their needs met, the experiences of children in these situations can be minimised or lost. It can be hard for workers to actually witness and hear the effects of abuse and neglect on children. Killen proposes (1996:793) that workers find ways to protect themselves from really confronting the effects of abuse stating 'Our ability to close our eyes to the suffering of children seems at times to be unlimited and I am not speaking first and foremost of society, but of us as professionals.'

Killen goes on to describe a projective identification that can occur where we project onto the adult parent our own feelings about what we believe parents would or should feel and be toward their children, instead of empathising with, and facing, the parents' and children's realities. This can lead to plans and goals which have little to do with either the parent's potentials or the child's needs. As a result, we can base our work on hope and optimism where there is no indication this is warranted.

Killen also states (1996) that children learn at a very early age what is expected of them, and these children learn that they are to look after adults, even protect them. This is often referred to as 'parentification' where children have to be the adult in the relationship. She suggests they then sometimes look after professionals by telling us what we want to hear, by appearing to be coping and indeed often helpful. Children learn what the adult world does not want to know and what even we as professionals cannot cope with. It is crucial that we try harder to see and hear children's real experiences.

Effects and harm to children

There is increasing research into the effects of experiencing harm and/or neglect for young children. We now know that childhood trauma and neglect both have wide ranging impacts on brain development and may permanently modify an individual's vulnerability to psychiatric disorder (see Kozolwska & Hanney, 2003:75). Perry (2001) cautions workers to assess carefully when a child is described by the parent or others as being 'a good baby'; this may be an indication of what he describes as 'dissociative continuum' for children who have been exposed for some time to abuse and/or neglect. He explains that babies have 'early alarm stages' where they attempt to attract the attention of a caregiver, through facial expressions, body movements, and vocalization or crying. Perry states that where there is a regular absence of an appropriate reaction to these attempts, the child will abandon the early alarm response, appearing 'good' or compliant.

Perry (2001) also describes how in the face of a persisting threat or neglect, the infant or young child will activate other neurophysiological and functional responses that are dissociative adaptations. He describes a variety of mental mechanisms to disengage from the external world and attend to the stimuli of the internal world. This can involve distraction, avoidance, numbing, daydreaming, fantasy, depersonal-isation and in the extreme fainting or catatonia. Slightly older children can report 'going to a different place' during these times. Perry says that observers will report these children as numb, non-reactive, day dreaming or staring off with a glazed look (Perry, 2001). There is a danger that this can be interpreted as them 'being used to it' or not affected by their environment.

Other maltreated children, according to Kozolwska and Hanney (2003), develop strategies that are likely to elicit parental attention, even if it is negative. This acting out behaviour, such as hyperactivity, hypervigilance and behavioural impulsivity can be, and quite often is, diagnosed as ADHD or other similar disorders. This locates the source of the problem as within the child, which does not require change in the family as a whole, and is usually 'solved' through medication. However, the same behaviours can be viewed as an adaptive trauma response from exposure to violent and chaotic homes, where frequent scanning of the environment and quick responses to threat are advantageous (see Kozolwska & Hanney, 2003:75). This view sees the child's behaviours as an understandable reaction to an environment which has not met their needs for boundaries or taught them how to contain themselves.

What about resilience?

Increasing research is being done into the ability of some children to withstand significant childhood trauma and disadvantage. Gilligan (2002/2003) defines resilience as the capacity to bounce back from, or transcend, adversity. This work is encouraging and gives great insight into the role that caring adults can play in the lives of children to mediate the effects of less than ideal environments. However, as Perry (2001) notes we do need to be cautious not to minimise the seriousness of some situations because the child appears to be coping, or because resilience research tells us they may be alright eventually - the risks are too high. This is especially problematic in situations of neglect and emotional abuse, where it is often no worse today than yesterday, and months, even years can go by with nothing changing before workers finally intervene on behalf of the child.

Daniel (in Tanner & Turney, 2003:27) suggests that 'the three intrinsic factors most likely to contribute to resilience in the face of negative life events are a secure base, good self esteem and a sense of self-efficacy'. Hence, the author goes on to outline that the experience of neglect from a parent with their own all consuming mental health issues, is most likely to undermine the very factors that underpin emotional well-being and that act as a buffer from the emotionally damaging effects of adverse experiences. We need, therefore, to be careful not to misuse resilience as an excuse for not making the tough decisions.

What is good enough?

One of the most difficult situations mental health workers face is where parents are trying, but care is still not 'good enough'. It can be too easy to put off tough decisions about capacity to change and those who work in the field are well aware that more often than not, we are looking for an adequate standard of care, not an optimal one.

There is no agreed standard about what is 'good enough'. Decisions are subjective, on a case by case basis, and while this allows room for clinical judgment, it can leave mental health workers feeling very vulnerable and uncertain when they know these decisions are life changing for others. Mental health workers can understandably feel very uncomfortable making such serious decisions when there is not an objective tool or standard to use. Literature searches find little by way of practical or agreed tools for assessing the adequacy of parenting. Unfortunately there is also rarely time for considering and checking all the literature and research when a decision needs to be made. This has led to increasing use of tools and checklists for children at risk, which although useful as guides, are rarely able to capture all factors and still rely heavily on clinical judgment.

Workers' reluctance to 'give up'

When we have invested a lot of time working with an adult client, seeing some progress, hoping for more, it can be very hard to acknowledge that things are either not changing, or are not progressing fast enough for the child. There can be a sense, conscious or unconscious, that we have failed as workers, that it was our job to solve the adult's issues, not punish them. Rather than recognising that some adults are unable to change to meet the child's needs, we can run around trying so hard that we fail to see that change is not occurring and that we are more invested in 'success' than the client. We can overlook the needs of the child and this can lead to years of postponing the inevitable, sometimes resulting in removal after it is almost too late for a successful outcome for the child.

When is progress not quick enough? When is it too harmful?

The question of timeframes is something that also arises in situations of neglect. Often the neglect a child is experiencing is no worse today than it was yesterday, or last week, or six months ago - so why act now? Chronic neglect is hard to reconcile with the incident based approach to child protection that has dominated over the past two decades. Neglect often fails to provide a 'trigger' episode, and the term 'abuse' connotes a ring of urgency that 'neglect' does not.

Tanner and Turney (2003) state that this type of neglect is characterised by unremitting low level care and an often ingrained sense of hopelessness within the family. They suggest that best evidence thus far recommends long term intensive support, often for between 12 and 18 months, for changes to occur. However, as the authors note, these timeframes are not without consequences for children. Over time, particularly where nothing changes, the worker may even find themselves getting 'drawn in' and becoming used to a level of care that if encountered in a new situation would strike them as unsatisfactory. How long is too long? If we have the child's best interests at heart, too long is any time after it becomes clear that the adult is unable to make the necessary changes or that it will take too long, despite the desire to change.

The illusion of change

We also need to be careful that workers are not being confused by the illusion of change. Sometimes, in our own hope to see things improve, we can read more improvement into a situation, focusing on improvements that are not actually about change for the child. We can focus on things that are more easily achievable, but do not address the neglect. There are consequences for adult clients if we fail to acknowledge they are having difficulty meeting the required standards. It can result in expectations and demands that are beyond them, and lead to new disappointments. This can also be a form of collusion – where the worker and the parent know deep down the parent can't do it, but no one is prepared to shatter the dream – this actually sets parents up to fail in the long term. It is also irresponsible in terms of our obligation to the child.

We are, as Killen (1996:793) states, telling parents, without saying it, 'I cannot see you for who you are'. By not acknowledging their limitations we imply without meaning to, that they are not good enough and that we have to create a more favourable picture of them in our mind in order to accept them. This can then make it impossible to work on or even discuss some areas of the parents' life in which they feel inadequate or want assistance. We can either play into their denial, or collude to keep certain aspects private. They learn that the worker wants to see that they have it all together in that area.

Making judgments

To come to a decision that a situation is not good enough, to feel the true weight of responsibility this involves, provokes anxiety, fear and conflict within us. And it should! This should never be an easy decision, it is good to question, talk the situation over with others and debate it. What is not useful is to avoid making the hard professional judgement calls. Workers often hope for a clear basis on which to make the decision and incident based abuse (such as sexual and physical abuse) can provide this. But situations of omission rather than commission, that is neglect and some forms of emotional abuse, are unlikely to be so clear cut.

Tanner and Turney (2003:26) state that judgments about neglect typically are value laden in terms of standards about adequate care, a position compounded by the workers who are often unwilling to pathologise families who may already be disadvantaged by poverty: 'So while there may be a level of agreement about the definition of neglect, the issue of thresholds - deciding when a particular situation has reached the point where intervention is necessary - is not always straightforward.'

Personal reactions to the work and its effects

The emotional challenge of working with adult parents who have the desire to change, but where this is not in a quick enough time frame, is very real for mental health workers. It is understandable we sometimes shy away from making tough decisions. As Killen notes (1996), we work in an highly emotionally charged field, and as professionals we have to find ways to both function and survive. Copan, Krell, Gundy, Field and Rogan (1979 in Killen, 1996:791) identified a range of feelings which seemed to interfere with effective service delivery from workers including:

- anxieties about being physically harmed by angry parents;
- the serious nature of the effects of a decision;
- a need for emotional gratification from clients;
- feelings of incompetence;
- denial or projection of responsibility; and
- feeling totally responsible for what happens to families.

Killen's 1979, 1988 and 1996 studies of welfare workers in general found that even seeing neglectful and abusive processes is a continual struggle for workers (see Killen, 1996). These findings are backed up by the Australian research of Goddard and Stanley (2002) in Victoria, which proposed that workers experience a form of hostage adaptation, that results in them minimising or not seeing the seriousness of situations, in order to be able to continue working in them. This again raises the difficult issues surrounding 'seeing double'.

Can it be any easier?

How much simpler it would be if someone was able to come up with a quick and easy test that would tell us if children were suffering 'too much' in any given situation - an objective measure, something to rely on not only to make the decision, but to make it easier to explain our actions to parents. But no such tool exists. There are structured risk assessment tools and checklists that can provide some guidance (for example, the NSW Health Mental Health Outcomes Assessment Tool or MHOAT http://www.health.nsw.gov.au/policy/cmh/mhoat/). However these risk assessment tools are usual for the more obvious forms of abuse at the front end of service provision, and tend not to capture the complexity of the types of situations being described in this paper. Saunders and Goddard (1998) also caution that there is a danger that any structured risk assessment process can be less about protecting children or workers, and more about protecting bureaucracies from criticism. Even if such a model were available, it is unlikely that it would stand the test of time, because our knowledge of the needs of children changes and grows, as do the theoretical underpinnings on which our professions are based.

Culture of reminding and discussion

Mental health services need to work to create a culture where the needs of children are recognised and discussions around 'good enough' care are welcomed and encouraged. It will never be, and should never be, easy to make such serious decisions that have implications for other human beings. Even if our motives and information are appropriate, questioning,

deliberation and consideration should always be a part of the process.

The main method for achieving these goals in most agencies is via supervision. Yet Gibbs (2000) cites many Australian and overseas studies that show that workers often believe that they get insufficient supervision and are dissatisfied with the quality. The supervision environment needs to be safe enough for workers to recognise that it hurts to see children's pain, that it is alright to be angry with parents and that we will feel grief, ambivalence, and aggression towards clients at times because of these issues. We need to be able to acknowledge the dilemma of trying to 'see double'.

Goddard and Stanley's (2002) Victorian study shows that staff supervision in a range of disciplines, has seen an increasing move to procedural requirements, with work allocation and administration being the focus. This results in less attention being paid to workers' professional experiences, with their reactions and needs being discounted. Gibbs' (2000) research would also suggest that the focus of supervision is most often about task and ensuring that work gets done, while workers feel neither cared for nor supported. Mental health services need to take heed of these findings and ensure their supervisors take active responsibility for providing supervision that allows exploration of these issues. Munro (1999) goes even further and suggests the useful supervision strategy of asking a worker in these situations to argue the opposite view and explore how they may be wrong in their decision making.

Conclusion

As hard as it can be to witness the struggles of some parents attempting to change their situations, ultimately if a situation won't change, can't change, or it will take too long, then the needs of the most vulnerable family members, the children, have to be prioritised. The short and long term effects matter, whether there is intent or not. Parents do need to be given a chance to improve their situation, but mental health workers need to continually ask the key questions: what is their capacity for change, and will it be fast enough? Workers also need to be given permission to say 'enough is enough'.

These are tough questions that mental health workers face, often without the framework or opportunity to reflect adequately on the basis for their decisions or the implications of their deliberations. In fact quite often, if considered in their full depth, these issues become almost overwhelming and the emotional challenge is very real for workers. Killen (1996) also reminds us that the temptation towards denial is not a phase, but a process that we have to continually confront within ourselves and in society. We have to force ourselves to see the child's experience: as T. S. Eliot said 'Human kind cannot stand very much reality.'

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