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CHILD ABUSE, REHABILITATION, AND POVERTY: A QUINTET OF PROBLEMS ENTAILED BY THE DOMINANT DISCOURSE

ABSTRACT
Available empirical evidence shows that rehabilitation programmes for families at risk for child abuse do not prevent further abuse in the majority of cases. In this paper five problems that may account for this are discussed. These are the problems of denial, cooperation, conformity, role confusion and countertransference. It is argued that this quintet of problems is partially rooted in the way in which risk and rehabilitation have been socially constructed within the dominant discourse concerning child protection. Finally, the way in which poverty potentiates the impact of these problems is explored.

THE ROAD TO REHABILITATION
In Ireland, the UK and the US, the road to rehabilitation, following child abuse is clearly charted and socially constructed as follows. Where physical or sexual child abuse has occurred and statutory agents are satisfied that the injuries or testimony of the child or other family members warrant a designation of child abuse, the statutory agent is required by the state to take steps to reduce the risk of further abuse occurring. The two most common strategies are to arrange for the child to be placed in care or to require the alleged abuser to leave the household of the abused child.

Once the immediate risk of re-abuse has been dealt with through one of these strategies, statutory agents are then required to arrange for the risks of re-abuse within the child's family to be reduced if possible. This will enable the child to live with both parents again without risk of further abuse. Usually the process of risk reduction involves the parents and the child engaging in some form of psychosocial consultation with an expert mental health professional. Often the mental health professional is selected by the statutory agent.

THE AIM OF CHILD PROTECTION SYSTEMS
Within this dominant discourse concerning child abuse, the primary aim of child protection systems is to minimize harm to children. Harm, in
this context, includes both short term difficulties and long term sequelae. It also refers to a wide variety of well documented difficulties in the physical, psychological, familial and broader social domains that result from the occurrence of child abuse. Risk factors for the occurrence of physical and sexual child abuse have been clearly established by thorough and rigorous research conducted within a positivist framework. These have been integrated into a number of multifactorial systemic models. These models and the research on which they are based inform the practice of many professionals working with families at risk (Cicchetti & Carlson, 1989). In particular, they inform the way in which rehabilitation programmes for families at risk are conducted. According to this body of knowledge, risks may be reduced by giving families (1) practical help with housing and household management (2) social help with child care or child management and (3) counselling or psychosocial consultations to help with intrapsychic or interpersonal difficulties. Different combinations of these interventions are offered depending upon the risk factors present in any particular case.

REHABILITATION DOESN'T WORK

Available evidence suggests that the majority of family rehabilitation programmes developed as part of child protection systems are ineffective in reducing risk and injury (Cohn & Daro, 1987). In a major review of treatment studies involving over 3000 families, it was found that between 20% and 87% of children who suffered physical abuse were re-abused following treatment and for sexual abuse re-abuse occurred in 16% -38% of cases (Jones, 1987). These studies spanned more than a decade and included projects on both sides of the Atlantic.

In this essay some of the reasons for this are explored. These explorations are based on my reading of the mainstream child protection literature and clinical observations made over a seven year period (1984-1991). During this time I was working as part of a multidisciplinary team offering assessment and rehabilitation services to families where child abuse had occurred. The team operated within an NHS outpatient Child & Family Clinic. Accounts of this work have been described elsewhere (Carr, 1989, 1990; 1991; 1994; Gawlinski, Carr et al., 1988; Irving, Carr et al, 1988.)

Five problems seem to me to be entailed by rehabilitation programmes informed by the dominant discourse which has evolved around child protection. I have termed these the problems of denial, cooperation, conformity, role confusion and countertransference. These problems are elaborated below. All five problems are potentiated by poverty. More specifically they are exacerbated by the social exclusion, colonization and marginalization entailed by poverty. Members of poor
families are excluded from participation in many valued social processes and institutions. Through accepting assistance within the context of the welfare state they are colonized and their autonomy is eroded. With eroded autonomy and without participation in important social processes and institutions they become marginalized. What follows is an exploration of the impact of poverty and these associated processes on a quintet of problems which characterize practice in the child protection field.

THE PROBLEM OF DENIAL

A core requirement for the viability of rehabilitation programmes, according to statutory agents, is that abusers must accept responsibility for abuse. Two other requirements are that parents accept that the way their family life is organized poses a risk to their child and that they are responsible for the risk and its reduction. Parents who cannot accept these responsibilities are unsuitable for rehabilitation. In short, for rehabilitation to work, statutory agents must be satisfied that parents are not locked into a process of denial.

The argument within the dominant discourse is that by giving up denial the abuser is agreeing to accept a new self-definition: that of an abuser. Once this problem-saturated identity (White, 1993) has been accepted, then rehabilitation can proceed.

For many abuser's the costs of giving up the process of denial are very high. It lead's inevitably to punishment for a criminal offence. Rehabilitation is rarely an alternative to punishment. (Although there are exceptions to this, for example Giaretto, 1982). At a broader cultural level, giving up the process of denial leads to stigmatization and ostracization rather than acceptance and understanding. Within the family, giving up the process of denial has negative consequences for abusers because they face the possibility of rejection, anger and lack of forgiveness from other family members. At personal level, giving up the process of denial and jettisoning the rationalizations that allow the abuser to justify his or her violence, creates the risk of extreme self-criticism. This lack of self-acceptance may lead to personal disintegration.

For victims of abuse, when the abuser gives up the process of denial there are many benefits. The abuse stops and there is a sense of safety. However, there are many hidden costs. The victim has to grapple with conflicting feelings of anger and loyalty towards the abuser and towards those family members who denied the abuse also.

Giving up the process of denial also has negative consequences for family members uninvolved in the abuse. They must accept that one of their kin whom they trusted is capable of betrayal and violence and that they have failed to recognized this or to protect the victimized
child. They must also deal with suspicions that the victimized child provoked that parent into the abuse and that the victim has been tarnished by the experience. These issues give rise to conflicting feelings of anger and loyalty towards the abuser and the abused child along with feelings of personal guilt.

The benefits of giving up the process of denial are the possibility of public and familial forgiveness and personal atonement. However, the route from giving up the process of denial to these benefits is rarely clear and the way in which the abuser can move to a position where he or she is a person with a problem rather than a problem-person within the family and society is usually obscure.

From this analysis it is obvious that the costs of giving up the process of denial are high and the benefits are unclearly defined. When child abuse occurs within a poor family the process of denial is strengthened by an awareness that giving up this process will lead to further social exclusion and marginalization for the family as a whole, but particularly for the abusing parent. There is also an awareness that the level of colonization will increase if the process of denial is given up and rehabilitation embarked upon.

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The problem of denial, in my view, is a major factor contributing to the failure of rehabilitation programmes. A discussion of the reasons why child abuse is constructed in such a way as to facilitate the denial process will be reserved for the final section of this paper.

THE PROBLEM OF CO-OPERATION
For a rehabilitation programme to be viable, a second requirement is that the parents and/or the child co-operate with the statutory agents by arranging for risk reduction.

Within the dominant discourse, the argument is that once the parents have given up the process of denial, they will want to co-operate with statutory agents in reducing the risk of child abuse. There is also an assumption that co-operation will be possible within the context of a statutory framework such as a care order or wardship.

However, there are problems with this social-construction of co-operation. Co-operation typically requires trust on both sides. The relationship between statutory agents and parents who have had their authority usurped by the state is based on mis-trust. The state does not trust the parents to meet the child's needs and the parents do not trust the state who have disintegrated their family. Mis-trust is the core of the problem of co-operation.

Because of their marginalized position, members of poor families are more likely to be mistrustful of professionals who they construe as powerful contributors to their marginalized position. This mistrust makes co-operation in rehabilitation problematic.
Parents and children may act as if they trust statutory agents so that they may become reunited. However, the risk of abuse may remain. The problem of co-operation is a second factor contributing to the failure of rehabilitation programmes.

THE PROBLEM OF CONFORMITY
A third requirement of rehabilitation programmes is that the parents and/or the child demonstrate that the strategy for risk reduction that they have chosen conforms to prevailing ideas about how best risks may be reduced. It has already been mentioned that within the dominant discourse it is accepted that the risks of child abused may be reduced by offering families practical help with household management; social help with child management; and psychosocial therapy for intrapsychic and interpersonal difficulties.

Usually families have little difficulty conforming when they are required to accept practical help or social assistance with child care. Many have considerable difficulty co-operating with counselling and various forms of therapy. This is in part a skills problem and in part a motivational problem. Often parents of families where child abuse has occurred have not got the skills to benefit from office based talking therapies. It is also difficult for anyone to benefit from counselling or therapy when they are threatened with the continued disintegration of their family if they refuse to conform.

Verbal skill-deficits and coercion into verbal psychotherapy are two faces of the problem of conformity. The assumption within the dominant discourse is that psychotherapy is accessible to people regardless of their verbal facility and that a coercive context does not compromise markedly the effectiveness of such interventions. In my view, these assumptions are problematic and may account in part for the failure of rehabilitation programmes.

Verbally based psychotherapy and counselling has been shown to be relatively inaccessible to people who live in a context characterized by poverty (Lorion, 1978). Thus families who live in such contexts may have particular difficulty conforming with rehabilitation programmes that entail such therapy. Furthermore, conforming to the requirement of mandatory therapy may be particularly problematic for families living in poverty since it reflects further colonization. It is not surprising that such families attend therapy erratically and often with an agenda that differs from that of the treatment team. Typically, frustrated rehabilitation teams allude to these conformity problems by describing the family as manipulative or resistant.

THE PROBLEM OF ROLE CONFUSION
Within the dominant discourse, the terms monitoring and support are
often mentioned as the dual function of social workers in child care cases. There is an assumption that families at risk may be monitored by statutory social workers and also supported or rehabilitated by them or their closely aligned colleagues in the health service.

Our own clinical experience shows that most families have considerable difficulty in accepting support or rehabilitative consultation from professionals whom they also construe as fulfilling a statutory risk monitoring role. Indeed, parents and children in multi-problem families may have difficulty drawing a distinction between the roles of statutory agent and therapeutic agent. Both are seen as fulfilling a statutory monitoring role. In the minds of such family members the coalitions between the statutory agents and therapeutic agencies may appear far stronger than those between the therapeutic agencies and themselves. In the face of such role confusion, families have difficulties participating in rehabilitation programmes.

Families socially excluded and marginalized by poverty are uniquely prone to the problem of role confusion. Because they are on the periphery of society, the main distinction they make is between families like themselves who are marginalized and powerless on the one hand and powerful professionals from official agencies on the other. With this as the superordinate distinction, often the subordinate distinction between the roles of statutory agent and therapeutic agent is not drawn (Crowther et al., 1990).

THE PROBLEM OF COUNTERTRANSFERENCE
A major problem faced by professionals and non-professionals in helping families reduce risk is retaining a non-aligned and relatively neutral position with respect to each member of the family. Workers involved in the rehabilitation of child abuse find themselves experiencing extremely strong and disturbing sets of emotions. Within the literature on child protection practice these experiences have been referred to as countertransference reactions (Carr, 1989)\(^1\).

In cases of physical child abuse the two commonest countertransference reactions are *rescuing the child* and *rescuing the parents*. In the former reaction, the urge is to protect the child at all costs and to deny any loyalty that the child may have to the parents or any competence or potential for therapeutic change on the part of the parents. In the latter reaction the urge is to protect the parents from criticism raised by other professionals and to deny any parental shortcomings. Professionals within the same system adopting these two countertransference reactions tend to polarise and have difficulty cooperating with each other and the family with whom they are working.

In cases of intrafamilial child sexual abuse *rescuing the father*
is one common countertransference reaction. The other is *rescuing the mother and child while persecuting the father*. The first reaction leads therapists to deny evidence pointing to the father's culpability and to highlight the father's strengths as a parent. The second reaction is associated with an urge to split the father off from the rest of the family and to deny any loyalties that other members may have to him. These two countertransference reactions are complimentary and professionals experiencing them may tend to polarise each other thus compromising their ability to work co-operatively in the service of the clients.

If therapists act out their countertransference reactions their emotionally driven aggressive or protective behaviour interferes with their capacity to help the families with which they work to change the way they organise their lives so as to reduce the risk of child abuse. The problem of countertransference is therefore yet another factor which accounts for the failure of rehabilitation programmes.

Child protection workers' countertransference reactions (Carr, 1989) to families where child abuse has occurred may be intensified when such families live in poverty. Abused children from poverty-stricken families may be construed by some child protection professionals as doubly victimized: victimized by poverty and victimized by the abusing parent. In these instances the intensity of these professional's countertransference reactions to the abuse (notably *rescuing the child* or *rescuing the mother and child and persecuting the father*) may be potentiated by the additional perceived victimization of the child through living in an impoverished family.

Parents who have abused their children or who are alleged to have done so may be construed by some child protection workers to be doubly victimised: victimized by poverty and then victimized for being a child abuser (which such professionals construe as an uncontrollable response to the constraints imposed by poverty.) The poverty of such families potentiates countertransference reactions (like *rescuing the parents* or *rescuing the father*) that such child protection professionals experience.
CONCLUDING COMMENTS

The five problems discussed in this paper are not trivial difficulties requiring technical solutions. Rather, they are serious difficulties that are rooted in the way child protection has been constructed within the dominant discourse.

With the problem of denial, it is clear that many parents who have abused their children would be prepared to give up the process of denial if ostracization was not inevitable. This leads us to question why, as a society, we need to ostracize people who abuse their children, particularly if they are impoverished? One explanation for this ostracization rests on the process of projection. In our westernized culture we deny our own aggressive and destructive impulses and project them into abusers whom we then ostracize. This process of projection may be further facilitated if the abuser is already a member of a marginalized group such as the unemployed or the impoverished. This process of projection protects us from a more fundamental re-examination of the way in which we participate in the abuse of children on a daily basis. We do this, for example, by creating a judicial system which is fundamentally distrustful of children's testimony. We do it by propagating values that maintain a family ethos which permits violence and secrecy. For example in Ireland two common aphorisms are: *Children should be seen and not heard* and *Spare the rod and spoil the child.* There is a paradox here that subserves the problem of denial. The state and its citizens will not give up the denial of their participation in the abuse of children, yet they expect identified child abusers to give up their denial before admission to a rehabilitation programme. If, as a society we took steps to acknowledge our own daily abuse of children and our need to examine and change this we would be less likely to see abusers as problem-people requiring ostracization and more likely to see them as people like ourselves with problems requiring help.

Of course there are factions within society and within our own mental health professions who have begun both personal and political re-examinations of their culpability in relation to child abuse. When such professionals find themselves working shoulder to shoulder with colleagues who have not embarked upon this process, existing countertransference reactions may be intensified and polarization may occur.

Underlying the problems of co-operation, conformity and role confusion is the idea that abusers (unlike ourselves) can be coerced into mandatory psychotherapy and that psychologically they are capable of forging intrapsychic and interpersonal changes within a climate of mistrust. In short, as a society we are construing people who abuse children, particularly those who live in poverty, as different from
ourselves, as intrinsically mad or bad, and therefore subject to a different psychology than ourselves, a psychology that allows them to make therapeutic gains under coercion.

In this paper I have argued that the failure of child protection rehabilitation programmes may be due, in part, to the problems of denial, co-operation, conformity, role confusion and countertransference. These problems, which are potentiated by poverty, stem from us construing abusers as fundamentally different from ourselves. Similar arguments have been made by the Fifth Province Associates (McCarthy & Byrne, 1988; Byrne & McCarthy, 1988).

FOOTNOTES
1. Within the psychoanalytic tradition countertransference refers specifically to those aspects of therapists' emotional reactions to clients which replicate or resonate with their reactions to parental figures during infancy. However, the term is used within discussions of the doctor-patient relationship and in the child protection field in a broader way to refer to professionals' overall emotional responses to patients or clients. It is in this broadened sense that the term is used here and in our previous discussions of this issue (Carr, 1989).

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