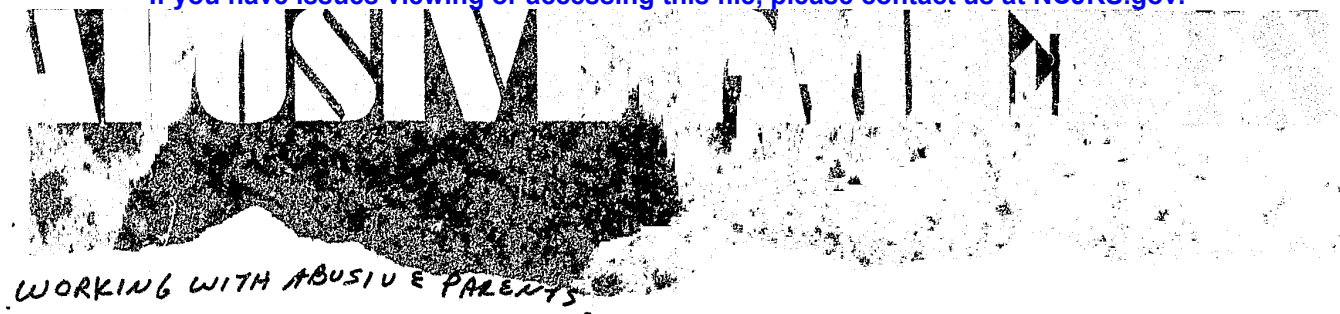

WORKING WITH ABUSIVE PARENTS

A Psychiatrist's View

by Brandt F. Steele

The following article is excerpted from the forthcoming OCD booklet, Working with Abusive Parents from a Psychiatric Point of View *by Brandt F. Steele, M.D. The booklet is one of a series of six being published by the National Center on Child Abuse and Neglect for use by professionals, community leaders, national organizations and others concerned with child abuse and neglect.*

The actions of parents or other caretakers which result in abuse of infants and children do not fall into any standard diagnostic category of psychiatric disorder, nor should they be considered a separate specific psychiatric disorder themselves. Yet to consider child abuse as a deviated pattern of childrearing rather than as a psychiatric disorder does not mean that abusing or neglecting parents are free of emotional problems or mental illness. They may have many psychiatric disorders, much the same as the general population.

Abusing or neglecting parents have about the normal incidence and distribution of neuroses, psychoses and character disorders which exist rather independently and separately from the behavioral patterns expressed in abuse of their offspring. Such psychiatric conditions may warrant appropriate treatment in their own right regardless of the coexistence of patterns of abuse.

There is a small group of abusive parents (less than 10 percent of the total) who suffer from such serious psychiatric disorder that they may be either temporarily or permanently unavailable for treatment of the more subtle problems of abuse. Among such conditions are schizophrenia, serious postpartum or other types of depression and incapacitating compulsive neuroses, with or without phobias. Ideally, such persons should be screened out of the regular treatment program and given inpatient or outpatient care as necessary. Also in this group are those parents who suffer from severe alcoholism, abuse of narcotic and non-narcotic drugs or from significant sexual perversion, and those who have been involved repeatedly in serious antisocial violent or criminal behavior. Such troubled persons need much more intensive, prolonged psychiatric care and social rehabilitation than can be provided in the usual child protective program. Until such measures have been accomplished, it is futile to try to alter the pattern of abuse.

It is obvious, then, that psychiatric consultation should be available in all situations where workers are dealing with the problem of child abuse and neglect. Proper psychiatric screening procedures ensure that the most troubled parents will receive the appropriate type of care and also protect workers from spending enormous amounts of time and energy on problems which require other special kinds of intervention. Working with such disturbed parents should never be delegated to the usual worker in child protective agencies. It is unfair to child, parent and worker, and the results are usually unhappy for all concerned.

A few words must be said about the socioeconomic status and racial background of abusing families. Unfortunately, because so many of the early reports and descriptions of child abuse came through welfare agencies and municipal hospitals it became a common belief that abuse and neglect of infants were associated with racial minorities and poverty-stricken groups of people. Such ideas still persist in many quarters, despite the increasing knowledge that child abuse and neglect occur among families from all socioeconomic levels, religious groups, races and nationalities. These facts should not be interpreted to deny the profound effect which social and economic deprivation, housing problems, unemployment, and subcultural and racial pressures have on the lives and behavior of the caretakers who abuse and neglect their children. Any stress can make life more difficult, and the ramifications of poverty can make anything worse than it would otherwise be. Such factors may be, and often are, involved in one way or another or in varying degree in many cases of abuse. They must be considered in every program of treatment of the families in which abuse occurs and appropriate actions and remedial measures undertaken through social case work, psychotherapy, counseling, vocational rehabilitation, financial aid, or any other method available to the agencies involved with the family.

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A word of caution is appropriate, however: no matter how necessary and useful it might be to improve the socio-economic status of parents, this should not in any way be confused with treating the more deeply seated personal character traits which are involved in abusive behavior. It is well recognized that individual acts of abuse may occur when the parents are faced with a crisis in relation to finances, employment, illness and so forth, but such crises cannot be considered adequate causes for abuse. Crises of this kind are equally common in the lives of many people who never display abusive behavior and, on the contrary, abuse can occur in families who are wealthy, well educated and well housed. The role of crisis as a precipitating factor in abusive behavior is an important one, however.

Working With The Parents

The first task faced by all those who try to work in the area of child abuse, regardless of professional background or lack of it, is that of coming to peace with one's own attitudes toward the problem of abuse and neglect of infants and small children. It is very emotionally disturbing to see a seriously injured or neglected baby, and we usually respond in either of two ways when confronted with the situation. We may disbelieve that such a thing could actually be true. We deny that parents could really have attacked their own offspring and that some other explanation for the situation must be found. Alternatively, if we do believe actual facts of what has happened we tend to have a surge of righteous anger and feel disposed to scold and punish the parents. Obviously, neither of these attitudes is useful in trying to do something to better the situation and help the parent improve his method of child care. Denial precludes any chance of dealing with the problem, and long experience of many people has indicated over and over again that criticism and punitive attack of the parents have adverse effect and no real therapeutic value.

Most useful in eliminating to the highest degree possible an attitude of anger toward the parents is a knowledge of how the parent's own life and difficulties help in understanding why he happened to become an abusive parent. Probably the thing which is most helpful in producing an understanding non-punitive stance in the one who is working with the abusive parent is to realize that one is not working with an abusive parent as much as one is working with a grownup person who was in his own early life a neglected or abused child himself. This one basic premise is probably the most important thing to keep as an organizing principle in the back of one's mind as one is trying to understand and work with abusive parents, regardless of one's own professional training or type of approach.

Characteristics and Problems of Abusive Parents

For most abusive parents their immaturity and dependency is essentially functional in nature and related to the emotional deprivation endured in early life. Hence it can be remedied to a significant degree by more rewarding and more satisfying experiences in adult life, especially those occurring during carefully managed therapeutic working relationships. However, it is necessary to keep in mind another cause for the inadequacy and inept parenting behavior. A small but significant number of children who were abused or neglected in their earliest years suffered organic brain damage due either to head trauma or to malnutrition during critical growth periods. As a result they had perceptual defects, diminished IQ and significant delay in language development. These deficits may produce in later adult life a condition characterized by significant lack of basic knowledge and attitudes of helplessness, immaturity and dependency.

If such organic causes of difficulty are suspected by the worker, careful evaluation by appropriate psychological testing and psychiatric examination should be undertaken. Such parents who are organically impaired will not respond easily, if at all, to the usual methods of working with abusing parents, whereas those whose immaturity and dependency are essentially functional in origin are much more responsive to interventions. If parental dysfunction due to brain damage is documented, therapeutic goals can be appropriately revised and limited, thereby preventing the expenditure of much unproductive effort by the worker.

The Constellation of Psychological Characteristics

No two abusive parents are exactly alike, of course, but in general all of them share certain characteristics to some degree in a variety of combinations. The main components of this constellation of factors involved in abuse may be summarized as follows: the special form of immaturity and the associated dependency in its various manifestations; the tragically low self-esteem and sense of incompetence; the difficulty in seeking pleasure and finding satisfaction in the adult world; the social isolation with its lack of lifelines and reluctance to seek help; the significant misperceptions of the infant, especially as manifested in role reversal; the fear of spoiling infants and the strong belief in the value of punishment; and the serious lack of ability to be empathically aware of the infant's condition and needs, and to respond appropriately to them.

The cumulative effect and dynamic interactions of these various factors make it extremely difficult for the parent to maintain equanimity and be successful as he or she tries to meet the demanding tasks of child care. The daily care of infants and small children requires large amounts of time, physical energy and emotional resources. The caretaker needs to have much patience, ingenuity, empathic understanding and self-sacrificing endurance—the very things which we see tragically lacking in abusive parents.

These parents have never had their own needs satisfied well enough to provide the surplus which would enable them to give to the infants under their care. With good reason they often doubt their own ability to do even a minimally acceptable job and they do not know where or how to seek help. In contrast to averagely successful parents, they do not have an adequate support system of spouse and extended family, or helpful neighbors, friends, pediatricians and so forth. Probably most important of all, they do not have a background of life experience which has enabled them to get pleasure out of life and to trust other people. They have no storehouse of spare emotional

energy but live a precarious hand-to-mouth emotional life, without a built-in cushion of hope, or available contacts to tide them over tight spots and crises. It is because of this that crises are crucially important in the lives of abusive parents and are often the precipitating factor in single events of abuse.

Treatment Modalities

The matching up of parent, worker and treatment modality is difficult and usually managed on a less than ideal scientific basis. Abusive parents are unique individuals, often with great reluctance to become involved in any form of treatment. Hence the type of treatment may be selected under great influence of what the parent will go along with at the given moment, rather than because of any theoretical preference for a specific method. It is equally true that the selection of a worker or a mode of treatment will be influenced by availability rather than theoretical principles. There is at present no data derived from thorough comparative studies which indicate how or why any one modality of treatment is more effective than another for particular kinds of parents. It is known, on the other hand, that even in the face of rather haphazard selective mechanisms, remarkably good results have come for parents who have been treated by many different methods.

By far the greater part of the burden of caring for abusive parents is carried by public and private social agencies. Although the traditional values and methods of social case work are maintained in such agencies, there is also an increasing use of other techniques and of paraprofessional workers under supervision. Social workers in health-based child protective services have also been active in developing innovative techniques of working with abusive families and social workers in many different kinds of programs have been active in developing services and training people in the areas of lay therapy, parent aides and homemakers.

Many different modes of psychotherapy have been used in the care of abusive parents and their families. A few parents have been successfully treated by classical psychoanalysis, but the general character structure and lifestyle of most abusive parents make this procedure quite impractical and probably unsuccessful. Psychoanalytically oriented dynamic psychotherapy in the hands of skilled experienced therapists has been extremely successful in many cases. With most abusive parents, the therapist must be more willing to adapt to patient needs and to allow more dependency than is ordinarily considered appropriate. Intensive psychotherapy which skillfully utilizes the transference, with avoidance of the development of a full transference neurosis, can stimulate great growth and deep structural change in these patients despite their severe immaturity and developmental arrest. In general, abusive parents respond best when psychotherapy is accompanied by supportive adjuncts associated with a cooperative child protective service or provided by individual social workers, lay therapists or group therapy. Skilled and experienced psychologists can also work successfully as counselors and therapists in both individual and group situations.

There is increasing use of group therapy as a mode of working with abusive parents, but as yet there is a dearth of published reports describing fully either techniques or long-term results. Groups may be composed of the single parent who has done the actual abusing or of mothers or of couples. Most groups are formed and led by professionally trained group therapists such as psychologists, psychiatrists or other mental health workers, although social workers in protective agencies have also taken up this pattern of treatment. It is thought by some that it is always wise to have at least two leaders, preferably a man and a woman, and especially if there is an attempt to develop a couples group the leaders must be male and female. A rapidly growing and extremely important movement is the development of self-help groups formed under the titles of Parents Anonymous and Families Anonymous. Organized on a voluntary basis by abusive parents themselves, with sponsorship and guidance from a professional worker, these groups provide a haven of safety and help for people who might otherwise be unable—out of fear and anxiety—to relate to any other kind of treatment program. After some time of working in such self-help groups the participants may be able to enter into other more extensive programs.

For those parents who have the courage and ego strength to enter into group programs, the process helps them express their emotions more openly, and also to become desensitized to criticism. They find out they are not alone in their troubles and their self-esteem is improved. As an especially important benefit the group provides channels for developing contacts into the wider community, first with group members and later with others, a kind of relationship in which the abusive parent has been woefully lacking. Experience suggests that even though group therapy may be the chief mode of treatment involved in caring for abusive parents, it may not be sufficient by itself. Contacts outside the group, either with group leaders on an individual basis or with other workers from other agencies or disciplines, are often necessary for the patient's best development and improvement.

Couples groups can help solve the common difficulty of getting both spouses involved in treatment. Husbands are notoriously reluctant to get help, but the presence of male workers leads some of them to accept either group or individual treatment programs. It is important for both partners in the marriage to be involved in rehabilitative efforts if at all possible, regardless of which one was the actual abuser. Abuse is always, in part, a family problem with one parent actively abetting or condoning the abusive behavior of the other, even though not actually participating in the abusive acts.

Behavior modification techniques have been used to obtain changes in the attitudes and actions of abusive parents in a relatively short time. Whether this technique has validity for long-term rehabilitation is not yet clear.

Other modes of dealing with abusive parents have used "role modeling" and techniques derived from learning theory. These modes are at least partly based on the assumption that the parent is in difficulty because he has not been given proper opportunity and material to develop adequate parental attitudes and actions. To some extent

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Sexual Molestation—*(Continued from page 21)*

sharing a report of venereal disease in a child with the statutory agency mandated to investigate suspected child abuse. Connecticut is the first state in the United States to clarify this issue in its child abuse reporting statute. According to the Connecticut law, all reports of acquired venereal disease in children under 13 years of age must be reported to Protective Services as well as to the State Health Department. In this way a simultaneous Protective Services investigation of the family may, if necessary, initiate steps to protect the child from further sexual molestation while public health authorities do contact investigation and treatment to prevent further transmission of the disease.

Identifying Abused Children

Since we cannot help the sexually abused child and his family unless we know they exist, how then can the major obstacles to identification detailed in this article be overcome? The key role of the physician in obtaining adequate medical corroboration of sexual abuse has not been minimized. Nevertheless, any concerned individual, especially when professionally involved with some aspect of child care, can do much to enhance recognition and reporting of this phenomenon.

First, since this is a phenomenon that thrives and proliferates in darkness, we need to open windows and doors and promote open public discussion of the topic. Increased public awareness is best stimulated by people who care enough to snatch every opportunity to arouse society's consciousness of the child victim of sexual abuse. Only then will the public sanction so vital to identifying and assisting these children be forthcoming.

Instead of wasting time during a crisis situation in helpless frustration with medical personnel who are uncooperative or unknowledgeable in this area, those who are concerned should identify and establish a relationship with reliable sources of medical help in advance. Knowledgeable and receptive physicians and health professionals in the community should be sought out so that ways to improve medical services to child victims of sexual assault can be jointly explored. Emergency rooms or private practitioners who do the most effective and sensitive job should be identified, encouraged and patronized. The services of new demonstration programs in this area should also be identified and sought.

Connecticut has recently received funding from the Children's Bureau, OCD to establish a Child Abuse and Neglect Demonstration Center that will enable a multidisciplinary consortium of agencies to work cooperatively toward diagnosis and treatment of families where child abuse, neglect or sexual molestation is a danger. One of the center's charges will be to delineate a workable range of effective services for child protection. As a last resort, it may be necessary to utilize legal and judicial means to identify and enforce the basic minimum standard of medical services that the sexually abused child is entitled to receive.

Lastly, it behooves every professional who deals with children to be aware that sexual molestation exists, to recognize danger signals—especially in high-risk children—and to be knowledgeable about his or her state's reporting laws and sources of help. Sexual abuse of children is certainly not the problem of any single profession or segment of society. A strong united effort is required to push back the last frontier in child abuse and assist the sexually molested child. ■

[1] *DeFrancis, Vincent,* "Protecting the Child Victim of Sex Crimes Committed by Adults," *Children's Division, American Humane Association, Denver, 1969.*
[2] *Ibid.*
[3] *"Gonorrhea: The Latest Word,"* Emergency Medicine, *Vol. 7, No. 2, February 1975, pp. 132-138.*
[4] *Goldstein, Joseph et al,* Beyond the Best Interest of the Child, *Macmillan Publishing Co., Inc., New York, 1973.*

A Psychiatrist's View—*(Continued from page 5)*

this is true, but these modes are based essentially upon the provision of material for cognitive learning whereas the deepest deficit in abusive parents is in the emotional or affective sphere. There is apparently a small group of parents who are neglectful or only mildly abusing, who can profit by the chance for cognitive learning of good parental techniques. However, the fallacy of believing this can be a standard method is demonstrated most clearly by the fact that in many cases, even those of serious abuse of a child, the parents are able to take care of other children in the family perfectly well. It is evident in such situations that it is not lack of factual knowledge which hampers the parents but the emotional difficulties involved with specific attitudes and mispereceptions of the parent toward an individual child.

Psychiatric understanding of the tragic long-term troubles of abusive parents can provide a perspective on the place which child abuse takes in their lives, and their attempts to adapt to their world. It offers a rational framework which enables workers from many disciplines—and who use various modalities of treatment—to help parents grow and to develop new and better patterns of childrearing. The most valuable ingredients, over and beyond intellectual insight, which enable parents to grow and develop are the time, attention, tolerance and recognition of the worth of an individual human being which the worker can provide. ■

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