HOW TO SUCCEED IN THE BUSINESS OF CREATING PSYCHOPATHS WITHOUT EVEN TRYING

Paul D. Steinhauer M.D., F.R.C.P. (C)

What I'm about to say today, you may find unpleasant. I want to talk with you about some *of* our failures, the odds we face, the reasons we fail and what we can do about them. I say our failures, not your failures, because I too am struggling to improve the quality *of* care for children whose families have broken down. For almost twelve years, I've consulted to two Children's Aid Societies, and at any one time I'm likely to be treating 2 or 3 wards or ex-wards in my private practice. I don't always succeed *of* course, but I want you to know that we work with some *of* the same kids. I've also been a foster parent. I've tasted both the joy and the despair that fostering can bring. I think I've even reached the point where I can look back on my experience with an objectivity that would have been impossible two or three years' ago.

I want you to think about the fact that day after day children are being damaged by societies that have undertaken to protect them. What's worse, much of this damage could - and should - be foreseen and avoided. That is not to say that you can cure - or even salvage - every case that comes your way. The clients you serve are, for the most part, families in the process *of b*reaking down. Your position is like that *of* the doctor whose patients are almost all handicapped or chronically ill. Try as he may, he cannot restore health. But there are a number of things - all *of* them important - he can do. He may be able to arrest the extent and rate *of* progression *of* the disease, or to minimize the frequency and severity *of* its complications. He can help child and family compensate for some *of* the more destructive effects of the illness. Finally and just as important, he may be able to help them face and overcome the limitations, anxieties and discouragement resulting from past damage by providing an antidote for feelings of helplessness, resentment and despair that threaten to overwhelm and immobilize them.

The Children's Aid Society worker, too, deals largely with children with a chronically advancing disease which, if not arrested, will be relentlessly progressive. Its end point is the loss of the ability to relate successfully to others leading ultimately to the creation of a full blown psychopath. Let's make a few things clear.

FIGURE I

This disease process (we might refer to it as personality deterioration) probably began before the child came into care. Unless he has made a ward at birth, the child probably has already been adversely affected by the destructive effects of his exposure to a severely disturbed natural family. Depending on the extent of their influence during the crucial formative years, he may already have suffered some irreversible scarring prior to admission.

Taking a child into care - even removing him from a severely damaging family will invariably prove traumatic. It may be necessary or even lifesaving but being separated from one's family is bound, at least in the short run, to be a profoundly upsetting

experience. The way in which the child assimilates the experience will either: (a) stop the progression of the personality deterioration. {b) undo much of the damage already done or (c) increase and make permanent the handicap.

Note that with each successive placement the extent of the disruption in the child's ability to relate is cumulative. Thus each placement, producing as it does a break in continuity and a separation from parental figures will leave the child more vulnerable to and less able to compensate for the effects of subsequent separations.

Notice that the progression of the deterioration is a jolting from, crisis to crisis in an almost predictable manner. Thus, crises seem not to be anticipated and avoided, but merely responded to.

The usual, point at which psychiatric consultation is sought is at or immediately prior the point of breakdown - and usually only after a number of breakdowns have occurred - rather than at the point where difficulties are first beginning to be apparent (i.e., before they have reached crisis proportions).

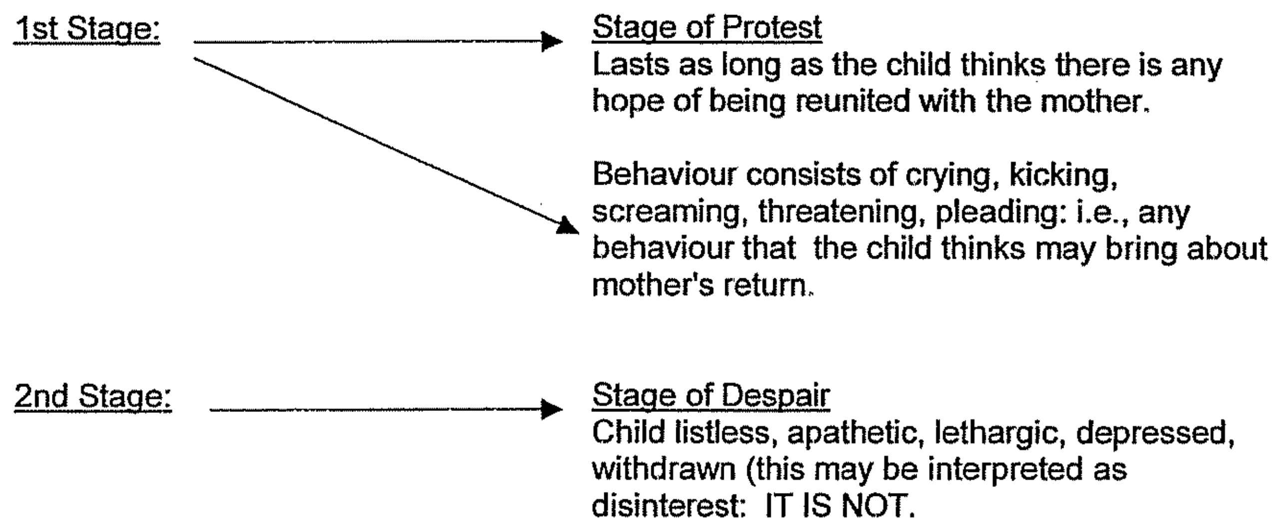
As you see, I am strongly emphasizing the importance of continuity and the traumatic effects of separation - especially repeated separation - on the development of the child. In this, of course, I am not alone. Bowlby & Robertson have written extensively and eloquently to this point, and Ner Littner in his address to this Association in May, 1970, at Niagara Falls -which I hope you will all read and reread- has suggested ways in which the traumatic effects of separation can be minimized. Much of Harlow's more recent work with monkeys has illustrated the importance of continuing relationships, not just with parents but with siblings, on the child's ability to develop normal social relationships. Most of us claim to believe in protecting children from unnecessary separations. But I suspect that often without realizing it we pay only lip-service to the importance of continuity. If we really believe - and God help the children who depend on us if we don't - that repeated separations and breaks in continuity are severely damaging to the developing child's capacity for relating to others, what can we do (a) to decrease as far as possible the number of separations and (b) to minimize the damage done by those separations that are inevitable. These, then, are our major questions for today. Before proceeding to them, let us review briefly both the immediate and long term reactions to separation. The longer I consult to Children *'s Aid Societies the more I am struck by how frequently workers, by and large, fail to* recognize and to appreciate the significance of separation reactions. There are, I think, three reasons for this:

(1) At the "cognitive level an incomplete understanding of the mourning process and its manifestations in children of different ages.
(2) At the clinical level, a failure to recognize the symptoms of aborted or pathological mourning, partly because of the masking effect of the child's defenses.
(3) At an affective level, the worker's inability to tolerate feelings stirred up in her by the child's pain. This results in a selective inattention if not an active discouragement of the child's using her to work through the mourning process.

Mourning has been defined as the psychological process set in motion by the loss of a loved one. It is aimed, ideally, at the giving up of the lost person. The purpose of mourning is to help, the mourner accept a fact in the outer world (i.e., that someone he loves is lost to him) and to help him make the corresponding change in his inner world (i.e., to help him gradually withdraw his love interest and investment from the lost person), leaving him free to reinvest these feelings in an available substitute. Mourning will inevitably occur in any child separated from those with whom he has formed an affect ional bond. The process is likely to be intensified, distorted and prolonged with each subsequent separation. A highly ambivalent relationship to the person lost will make it harder for mourning to be successfully completed.

DIAGRAM II

Typically, there are three stages in the mourning process:



From this point, the process may go in one of two directions:

(a) Mourning may be successfully completed. DIAGRAM IV. This will occur if mother returned in time, OR with the prompt provision of an adequate mother substitute:

NOTE:
Importance of time lag: Anne Freud: Period between loss of contact with own mother and time of attachment to permanent mother substitute is period most likely to result in permanent damage, especially if it is prolonged for either external or internal reasons.

(b) Mourning process may never be successfully completed. Either external OR internal factors that may interfere with a child's successful completion of the mourning process. DIAGRAM V.

External reasons — lack of adequate available mother substitute
agency policy: - further delay~ fragmentation by passing the child through an unnecessary interim placement.
- poor placement of child.

Internal reasons — that would prolong the period in limbo would include anything that blocked the child from being free to form a bond with an adequate substitute who was available. e.g.

1. interference of previous damage to the child - when in his own' family - from repeated separation
2. failure to adequately prepare the child for the placement.
3. failure. to help child especially (but also parent substitutes) deal with their reactions to the separation.

We have also, via the graph, emphasized the cumulative effect of aborted or pathological mourning in sensitizing the child to have exaggerated difficulties dealing with future separation. What, then, are the long-term effects of pathological mourning?

Permanent detachment: either doesn't relate at all or is shallow, superficial and manipulative in dealings with others

→ according to Bowlby, stage 3 of pathological mourning process

→ a lasting inability to become emotionally with other people, excerpt at the most superficial level

→ alternately, the child combines exaggerated demands for closeness with an inability to tolerate closeness and a need to distance

Other associated long-term deficits include:

(1) Persistent, diffuse rage:
Bowlby: "There is no experience to which the young child can be subjected more prone to elicit intense, violent and persistent hatred of the mother figure than that of separation."

(2) Chronic depression:
- related to degree to which basic needs for love and security have never been met.
- may present as frank depression: sadness; loneliness; hopelessness; self-destructive behaviour (including drugs); suicidal thoughts or attempts.
- may present more as continuing apathy; lethargy; lack of interest, drive and energy; inability to get started; to follow through.

(3) Chronic dependency:
(4) Asocial and antisocial behaviour:
- superego defects: failure to form stable enough relationships to allow for solid identification to occur. As a result:
- lack of appropriate guilt,
- diffuse feelings of shame, worthlessness
  - ego defects: partly a result of the greatly intensified rage and anxiety resulting from repeated deprivations, and partly failure to develop adequate system of inner controls and defenses to keep the expression of these within appropriate and socially acceptable limits.

(5) Low self-concept: This results originally from the child's never having felt loved, cared about sufficiently to incorporate (i.e., to form a picture within himself) of himself as a wanted and worthwhile person. This original lack is aggravated by his compulsive though unrecognized need to set himself up for repeated rejections, thus proving again and again that there is nothing good or lovable about him.

The stage of permanent detachment occurs if and when the energy and love withdrawn from the original mother fail 'to find an adequate substitute with the critical period. As a result, this energy remains unavailable to form relationships with others, and is instead withdrawn and turned back onto the child himself.

(a) Love and energy withdrawn from others may be re-invested in the child's own body. Initially this may result in excessive autoeroticism (thumbsucking, rocking, masturbation). Such children remain vulnerable to hypochondriasis and psychosomatic complains later in life.

(b) The love and energy may become invested in the child's self image causing him to become increasingly narcissistic. The narcissistic child is, concerned only with himself and his own needs. Shallow, superficial and self-centred, he will use others for what he can get, giving as little of himself as he can get by with. He may be totally, plastic, relating in an "as if" manner by feeding others what he thinks they expect rather than expressing what he really thinks. feels or wants.

(c) His love and energy may become over-invested in his own inner world of fantasy which then assumes more importance for him than external reality. This will lead to a progressive withdrawal and an increasing reliance on fantasy *as* a source of gratification rather than on real experiences and with other people. These alternatives are not, of course. mutually exclusive. Together they represent the end result of the process set into motion when a child is forced to submit to the trauma of repeated separations. Let me repeat again: the longer the interval between loss of contact with the child's own mother and the time of permanent attachment to a substitute mother the greater the hazard of severe and permanent damage leading ultimately to a child who is asocial and/or antisocial, incapable of trust, warmth or true intimacy with others.

This, then. is the process which we seek to reverse. or at least check. What can be done to arrest its progression and to minimize its social and emotional complications? What more can we do than we are already doing? Let's examine our opportunities for intervention at each stage of the process.

Point A:
PRIOR TO CHILD'S BEING REMOVED FROM HIS FAMILY:

1. Will Advantages Outweigh Disadvantages?

Recognize that removing a child from his family - or from a foster family where he has put down roots, however ambivalently and tentatively - will inevitably prove traumatic. We must weigh the known risks against the hoped for benefits. So potentially dangerous a procedure should only be considered when all alternatives short of separation have been adequately explored and found wanting.

2. Have **All** Other Possible Alternatives Been Considered?

The demand to take a child into care suggests a crisis within the family, a declaration of emotional bankruptcy. The family - and at times the child- may see only one solution to that crisis: removal and placement of the child. Often other alternatives - some of them quite workable - will exist although the family in their distress cannot see them. If made aware of alternate solutions, some families will be quite willing to try them. This will not always be possible of course. But by responding to the crisis by immediately removing the child one loses the opportunity of finding out whether less drastic but equally workable alternatives exist. The worker here is like the doctor whose patient has a severe and painful infection on the foot. Once she has amputated the leg, the question of whether less risky intervention could prove adequate while avoiding a permanently mutilating procedure becomes academic.

3. The Pressures on the Worker:
The worker may be exposed to great pressure - from parents, child or community - to immediately take a child into care. Her initial anxiety level (i.e., her attitude and responses) may either escalate the crisis or release tensions allowing for a more gradual and less damaging solution. When we are stampeded by family or community pressures rather than proceeding according to a plan derived from an adequate understanding of the case, the child is liable to end up out of the frying pan but deep in the fire. Pressures can often be withstood, if we are convinced of the value of determining our course before rushing into action.

4. Has there really been an adequate attempt to resolve the crisis without removing the child?
No child should be moved unless all other possibilities of resolving the crisis have been exhausted, or he is in immediate and serious physical danger. Yet often children are admitted to care where there is no immediate risk and after just a token attempt to explore alternatives short of placement.

By token, I have in mind two situations:

(a) A child is apprehended by a worker who may have seen the family once or twice but lacks any real understanding of the family dynamics, the true nature of the crisis, or the likely effects on child and family of bringing him into care.

(b) A worker has met with the family for *some* time but allowed the family to continue avoiding the crucial issues which should have been the focus of their casework. Often there is a long history of cancelled or failed appointments, frequent lateness, indirect complaints, increasing financial demands or avoiding issues which have never been faced openly and directly with the family.

5. Wherever possible, avoid taking total responsibility for the Child from the parents:

Admission to care may reinforce the family's scapegoating of a child, thus decreasing their willingness to remain involved in trying to find a solution to the problems that led to his coming into care. Once we make the child our responsibility, we make it easy for parents to feel the responsibility is no longer theirs. Particularly now when so many parents respond to conflict with adolescents by trying 'to unload them. we risk aggravating an already serious situation if we allow them to hand over to us their problem. Even if the child temporarily cannot live at home, make every effort to help the family continue to feel that he is part of their family as any possibility of reuniting them exists.

6. The importance of the overall plan:

Sometimes, despite our best efforts, it will be necessary to bring a child into care. Wherever possible this should be done on a <u>planned</u> rather than on an <u>emergency</u> basis. Admission to care is often seen as an end in itself (i.e., "There, now. I've removed him from that terrible situation.") rather than as a means to an end. (i.e., "How will this admission fit in with the overall plan of management for this child?"). The time to think of where a child should go <u>after</u> he is admitted must be <u>before</u> he is admitted. One should always work towards clearly defined goals derived from at least a provisional understanding of the case. As one proceeds, the results obtained may necessitate shifts in the initial plan. Nevertheless, without clearly defined explicit goals towards which both client and worker are working, one is in danger of drifting aimlessly or jolting from crisis to crisis without any real sense of direction.

7. Thorough assessment prior to admission to care:

In his address to this association in 1970, Littner stated: "Unless absolutely unavoidable, the entire diagnostic evaluation should take place before the child is moved from his own home. Temporary placements, whether emergency or diagnostic, should be avoided if at all possible." I could not agree more strongly. As a consultant, I am struck by the number of emergency placements that could - and should - have been

anticipated and planned for. The point at which placement becomes a possibility is the time for a thorough assessment to determine the nature and depth of the child's and family's difficulties. Even in a crisis where separation is unavoidable, one can often delay the Actual placement to permit an adequate assessment. To paraphrase Littner: "The more diagnosing and planning before the move, the less likely that a replacement will be necessary.

There is .a myth that until you take a child into care and live with him, you don't know what he is like. This is not true. It is also downright damaging. One can often anticipate quite accurately the difficulties a child will present following placement and the type of setting he needs. But all too often this sort of advance planning fails to occur. This is for two reasons:

(a) There is no time: In one agency 65% of all placements occur within 48 hours of the request for placement. Although the stated policy of the agency favours planned placements wherever possible, non-urgent. requests for consideration of a possible placement are frequently ignored, until the case is re-submitted some weeks later as an .emergency request. One often can – if convinced – delay emergency admissions until an adequate prior assessment has been completed. This will certainly allow for a more appropriate matching of a child and resource.

(b) Workers are often reluctant to plan on the basis of someone else's assessment: There is often a major lack of trust and "co-operation both between departments within an agency and between the agency and other assessment and treatment" resources. Clinics and consultants are not always right - but they are not always wrong either. Too often communication breaks down between departments, or between agencies and their consultants. As a result, the agency loses what the consultant might contribute to its understanding of the case, while the consultant misses out on the corrective feedback he needs to put his observations in perspective and to appreciate the options available to the agency. To anticipate in advance the sorts of problems a child will have and the type of resource best suited to his needs will require both an adequate assessment and some degree of trust and communication with those doing the assessment.

If this is not possible within your agency or with the consultants available to you, you should be facing this immediately, directly and frankly.

(8) Adequate Preparation for Placement:

Whenever possible, admissions should allow adequate time to prepare the child for the coming placement. He should be told as clearly and directly as possible why he is coming into care. He will need help dealing with his feelings about the separation and his fears about his new family. To do this properly will take time. It will also require pre-placement visits - not just a single token in-and-out visit; but a predictable series of

graduate contacts allowing the child to become familiar with the family or setting which are to be his. His reactions to each stage of this introduction will be monitored by his worker, who will ideally utilize cues from the child to determine his readiness to proceed to the next stage of placement. This should ensure that the child will never be faced with more anxiety than he can cope with at any given time. The more the child is helped to deal with his feelings about the separation and the more comfortable he is in his new environment prior to placement, the greater the chance of the placement taking, thus avoiding unnecessary and potentially damaging replacements.

In view of our knowledge of children's reactions to separation, it is shocking to hear how frequently pre-placement visits are either not made, or a single mechanical visit without follow-up is considered adequate preparation.

POINT B: The Point of Removing the Child from his Family:

The handling of the removal from the original family will prove critical in the child's subsequent adjustment and may do much to determine the stability of the placement.

Wherever possible, intermediate placements, either on a receiving or on an assessment basis should be avoided

The child's first placement, hopefully, will be his last. Wherever a prior assessment makes it possible to determine in advance the sort of resource best suited to a child's needs, he should be admitted directly to that resource.

The child coming into care for the first time is in a state of extreme dependency. In moving from chaos to stability, he will be extremely open to forming a close relationship if an adequate mother substitute is available. Should he do so (e.g. in a receiving home) only to have to be moved again, he will have been exposed to a second - and this time avoidable - traumatic separation.

Is there a risk in placing a child directly on the basis of even, an adequate advance assessment? There certainly is. But there is an even greater risk of admitting a child in a state of extreme dependency into an intermediate setting, encouraging him to become involved and then uprooting him - this time unnecessarily -- again. This can only have the effect of compounding the damage done by the earlier separation.

Although it is argued at times. that it is safer to admit a child to a temporary assessment home to determine his needs before deciding on a permanent placement, what is learned about a child in a receiving or assessment home frequently has little bearing on his ultimate placement.

Where he goes and when he leaves often depend less on his needs arid more on where a bed is available. There are, however, two situations in which an intermediate placement is justified:

1. One is when it is truly impossible to determine the placement of choice in advance. In such cases, there should be enough flexibility to extend what was originally intended as an interim placement into a permanent one, should this be in the child's best interests (i.e., should a meaningful bond between the child and a parent substitute in the interim facility develop).

2. The other exception is the child who, through a prior evaluation, is known to be so severely damaged that he is already incapable of forming a relationship. He should be spared the trauma and sense of failure that will almost inevitably result if admitted to a family setting. Such children are best admitted directly to an institutional setting - this might be a treatment centre, or a staffed rather than couple-operated group home, etc. - to avoid exposing them to a predictable failure and rejection.

Wherever possible, intensify rather than decrease efforts to work with the family at the point where a child is brought into care.

A significant percentage, especially of those older children coming into care for the first time, are likely to return to their families when they leave care. Our aim, therefore, should be that of attempting to reunite families with a clear conviction that whenever possible, this will be in the child's best interests.

Taking a child into care will further disrupt an already disturbed family equilibrium. If the child in care is scapegoated by the family, they may in his absence, close ranks in an attempt to finally extrude him. The act of taking a scapegoated child into care may reinforce this tendency by making it easier for them to wash their hands of him. The more ambivalent the bonding, the more parents and child must work through if they are ever to resolve the traumatic effects of the separation whether or not they ever live together again. The importance of this for the younger child is obvious. But even the adolescent who is old enough to live alone will be badly scarred if the feelings evoked by a traumatic separation are not resolved.

All too often agencies unwittingly block this resolution once the child is in care. This should be the time when efforts to work with child and family are intensified, not abandoned. Instead, once the child is safely in care, the family worker frequently attenuates or stops his contact with the family. The child's worker, meanwhile, is struggling to work with and plan for the child with little knowledge of his family situation. or the prospects of eventual return. The worst thing for both child and family at this stage is total isolation in which to consolidate their withdrawal from each other. The greatest care should be taken to avoid undermining whatever bonding and sense of responsibility for the child the parents still have. Both children and their families may strenuously resist attempts to bring them together for work on those problems that led to the original family breakdown. These resistances should be recognized as related to the same problems that led to the child's admission. Remember that parental rage

may mask parental anxiety and grief. A period away from each other may decrease tensions enough to allow tempers to cool and positions to be re-examined. This is the time to help both child and family deal with the feelings stirred up by the separation and explore and prepare for the possibility of return. Unless this is done, if the child returns. Home, it will be to the same highly pathological situation which he was recently removed.

Change of worker at the point of coming into care:

Some agencies are so organized that the worker who takes a child into care (i.e. the family service or protection worker) is replaced immediately upon admission by another worker from the child care department. This change of workers is often considered merely an administrative routine of no importance to the child. But the child, not infrequently, forms a strong tie to the worker who stood beside him when he was at his most vulnerable. To lose this worker suddenly and with little or no reasonable explanation just when he has lost his own family and faces the prospect of life with strangers, imposes .an additional burden on the child. She, who has been with him through the trauma surrounding his coming into care, is the natural person to help him face and begin dealing with the feelings evoked by the separation. Surely it should be possible to delay the change of workers and fade workers in and out more gradually after the child has settled in his new surroundings.

Recognize and deal with feelings about coming into care and separation:

Each of us deals with newly painful experiences in his own way and at his own rate. Faced with more anxiety than we can tolerate at any given time, we tend to block and repress the feelings that are too painful to face. We must do all we can to protect the child from having to repress the feelings stirred up by separation and placement. We can help by controlling the rate and predictability of the placement, and by helping the child recognize and deal with his feelings at each stage of the process. But, especially if the separation has been traumatic, it is essential that the child face his parents again and that he face and deal with his feelings about them. To avoid this under the guise of protecting him from further upset is to discourage him from completing the normal mourning process.

Littner has drawn attention to the *cost* of a gradual. predictable placement process in terms of worker's time, energy and the financial costs involved. But, and I quote him, "There is little doubt that it is far more expensive to treat the .problems created by failure to observe good placement technique. It is unlikely that all the traumatic effects of separation can be avoided, but we certainly can do a great deal to minimize them."

It" will not be easy for you, as workers, to help children deal with their feelings around separation. Children will fend you off using the same techniques they have used to protect themselves from adults who have hurt them in the past. They will make you feel

useless, inadequate, guilty, helpless and angry. Foster parents may resist and resent you. It will always be easy, once the crisis is over, to rationalize avoiding the frustrations involved on the grounds that you are no longer needed; you have no more time, your caseload is too large, the crisis is over, etc. It's only human to feel frustration and anger in such a situation. But if these feelings are not recognized and used constructively - if they lead you instead to withdraw~ reject or retaliate against the child - you will be compounding his problems by making it easier for him to repress rather than face and work through the feelings evoked by his separation.

POINT C: Management Following Placement

You are moving a child who is both disturbed and disturbing into a new - and possibly vulnerable - situation. The family that is expected to take him in may find the child's behaviour confusing and upsetting. If he reacts to them with the distrust, anxiety and rage he feels towards adults generally, they may respond at first with understanding and then, increasingly, with confusion, frustration, discouragement and resentment. He may upset their family's life, and there may be weeks, months or even years of giving before they feel they are getting something back. They may not realize it and they may resist accepting it but they will probably need your help in dealing with the negative component of their ambivalence if the placement is to survive. It's not your job to tell them how to be good parents - everyone has his own style of parenting and besides, in practical terms, they've probably had more experience at raising children than you have. Nor is it for you to compete with them by telling them how much better you understand or could handle the child, to change their way of life to fit what you feel are the needs of the child, or to convey messages from the child to them and from them to the child. But it is your job:

(a) to see that both they and the child deal with feelings and conflicts generated in the course of the placement,

(b) to see that feelings stirred up in daily living are dealt with openly and directly between them.

Again this may seem obvious. Unfortunately, this often does not show up in practice. Too often, foster parents are, initially, idealized and then, when a placement breaks down, blamed and scapegoated. The relationship between social workers and foster parents can be brittle. Too often, following a breakdown, one finds a long trail of indications of trouble that were never picked up or handled openly. Too many workers function from what might be termed a crisis mentality, when there's a crisis, I'll move in, but once it's settled, I'll pull back out. Unfortunately, this creates more crisis than it resolves, as it encourages dependency at the point of crisis only to frustrate it as soon as the crisis point is passed without having built a tension-relieving mechanism into the system.

Any request, verbal or behavioural, that a child be moved indicates that the placement is in trouble, but not necessarily that it is beyond saving. A vigorous attempt to help foster child and family face, identify and handle differently the disruptive feelings should immediately be attempted. Frequently the request will come in response to strong negative feelings that those involved are suppressing rather than handling directly. These may have little to do with the foster parents themselves, and a great deal to do with the interference of unresolved feelings the child has about his own parents. Too literal a response to such a demand may lose whatever chance there is of resolving the crisis short of separation. Should they be adamant in their insistence on removing the child, one would of course accept their position, but they should be expected to aid in minimizing the damage done:

(a) by confronting the child openly and directly, with their reasons .for insisting that he be moved,

(b) by being prepared to carry on long enough to alloy time for an assessment and adequate preparation of the child for his new placement.

(c) by agreeing to meet with the child and his worker after the move in an attempt to bring to the surface and aid the working through of feelings generated by the breakdown.

One might also comment briefly on the use of psychiatric consultation for children whose placements are in trouble. You will note that psychiatric consultation is usually sought only after the situation has reached the point of crisis. It could be much more helpful if undertaken when the situation was beginning to deteriorate rather than after it had reached the point of no return.

In summary, let me pull together what I've been saying into ten basic principles:

Taking a child into care involves major risks. Avoid removing a child from his family - or from a foster family where he has put down roots – whenever possible. Any demand for removal indicates a crisis which 'may' or may not' be accessible to alternatives short of separation.

Wherever possible identify situations which are likely to deteriorate to the point where the placement is threatened. A prompt but thorough clinical evaluation at this stage may do much to clarify the various factors in child and family contributing to the deterioration. The more clearly these are understood, the greater the chance of finding an alternative to placement. Even should this prove impossible, the assessment will still prove invaluable in helping define the child's needs and in guiding in the selection of a suitable placement resource, thus minimizing the risk of damaging replacements. This - not after the situation has reached the point of no return - is the time to consider psychiatric consultation.

Intermediate placements should be avoided wherever possible, and the child moved directly into a resource suited to his anticipated needs as determined by a prior assessment. Intermediate placement should be reserved for children identified as unable to tolerate a permanent placement, or those relatively few absolute emergencies where placement simply cannot be delayed.

Should a separation be unavoidable the damage done can be minimized:

By ensuring that the move is part of an overall plan of management rather than an isolated response whose long-term implications have not been adequately considered.

By adequately preparing the child for separation and placement. This involves dealing openly with the reasons for placement and with the feelings around this. It also requires a gradual and predictable introduction to his new setting at a rate that the child can tolerate without unbearable anxiety.

By bearing in mind that parental figures to whom the child has been bonded will continue to have emotional meaning despite physical separation.

The separation will cause the child to mourn, either overtly or covertly. The successful resolution of this mourning will be crucial in determining the degree of permanent damage the child will suffer as a result of the separation.

Particularly if the separation occurred without adequate preparation, every effort should be made to see that child and parents (or surrogates) see each other following the placement so that feelings stirred up but not faced can at least be out in the open. To avoid this on the grounds that it will prove unpleasant or traumatic is to encourage the child to repress the experience, thus facilitating the drift towards psychopathy.

Skilled and committed work with the foster families, despite the resistances and difficulties of all involved~ will be crucial if the number of replacements is to be minimized. The role of the worker must be kept clearly defined, and the danger of being drawn into competition with the foster parents or cast as a middle-man (messenger) between foster parents and child recognized. The worker must be aware of the child's prior disturbance, and avoid blaming foster parents for their reactions to the child's pre-existing pathology. Only if they are sure that the worker sees clearly (a) the degree of the child's disturbance and (b) the fact that it existed prior to placement with them will foster parents tolerate examination of their reactions to the child without extreme defensiveness. The primary role of the worker is to help child and family work out their relationship with each other by learning to deal both individually and together with the feelings - especially those of hostility~ anxiety, and rejection - they elicit in each other. To assume the role of an expert on child-rearing, or to attempt to

deal with the issues purely at the instrumental level is to invite failure. Current reality is important, but feelings left over from the past contaminate children's perceptions of the present and their behaviour. They are an essential part of the child's reality.

Learn more about child development, the process of mourning, the pathology of childhood, the techniques of working with children and families. It's not enough to care and to want to help. There is a body of knowledge available to you. Through reading, through in-service training, through your utilization of supervision; through better use of your consultants and, above all, through a critical examination of your own work, learn to evaluate your professional strengths and to recognize, and strengthen your areas. of weakness.

Be aware of how your own feelings towards your clients influence the work you do. When a client makes you feel anxious, frustrated, bored or hostile what happens? If you feel love or pity for a child; how does this affect your dealings with him and his family? How often do the quality and level of your involvement reflect more your personal reactions than your client's needs?

Recognize the difficulty that most children, foster parents, social workers - and, for that matter, child psychiatrists - have in dealing openly and directly with their feelings of rage. We all feel rage from time to time, whether we acknowledge it or not. The more successful you are in building a relationship with clients, supervisors and consultants in which all feelings, positive and negative, can be dealt with openly and directly, the more effective you will be. Sensitize yourself to both your own and your clients' indirect expressions of hostility (cancellations, lateness, complaints about the agency or former workers, the derisive use of humour, attempts at manipulation, repeated requests for more money), and use these to get at the source of the underlying anger openly and directly.

Foster parents know more about living with a child on a day-to-day basis than you do. Decisions affecting the child will also affect their family. They should be involved in any major decisions around the child. Examine communications with your agency. Better still, examine how you communicate within the agency, i.e. with colleagues, with supervisors, with other departments. What can you do to ensure that you face issues openly and directly in situations in which you personally are involved? How does this affect how others respond to you?

Some of you, I'm afraid, may feel that in speaking so bluntly of the natural history of the process we are struggling to contain I am being unduly depressing. When I began, I compared your work to that of the physician who treats almost exclusively chronically ill patients. One of the professional hazards he faces is that of being contaminated by the feelings of despair, helplessness and hopelessness emanating from his patients. Children's Aid Society workers, like physicians, can easily become trapped in the mire of their client's chronic depression, losing their objectivity and initiative. In attempting to defend themselves against this, they may avoid any recognition of feelings over which they have no control, thus focusing largely at an instrumental level. There is an

alarming trend in social work today in which, under the guise of being "practical, reality-orientated or health-orientated" workers ignore the presence and significance of feelings they would rather not have to deal with. To be effective, however, we must know and face head-on the destructive process we seek to contain. We must at all times remain aware of our separateness from the child and family, avoiding the contagion of their depression. If we are realistic in our goals,- i.e. if we aim not at cure, which could be grandiose - but at containment, compensation, rehabilitation and encouragement where possible, we can, achieve a great deal. Palmer's recent study strongly suggests that with better trained workers and with a greater conviction about carrying the theories to which they subscribe, it is possible to significantly decrease the damage resulting from family breakdown, to minimize replacements, and to help children assimilate the separation experience, thus checking the :otherwise inevitable drift into psychopathy.

We must learn what there is to know about children, about families, about the experience and meaning of separation, and then we must apply what we know with sensitivity, with strength, with determination and with consistency. Only then can we truly say that we are doing what needs to be done.

Children's Aid Society of Metropolitan Toronto

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