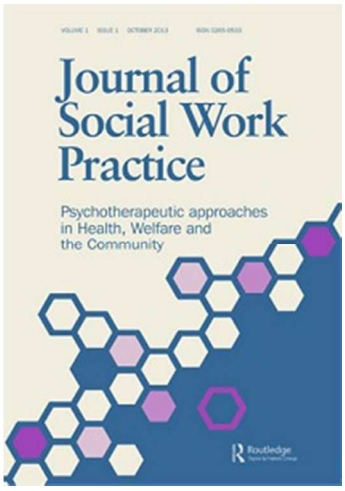

Risk and Parenting Assessments in Child Welfare Court Proceedings – A Psychodynamic Approach.

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Abstract

This article discusses a court directed parenting and risk assessment of a mother who has a chronic history of trauma and abuse. It addresses the complex unconscious dynamics that need to be managed by social workers when working with parents in court proceedings regarding their children. Often such parents present with their own complex histories of trauma and abuse and despite their conscious intentions to do so this has contributed to their inability to provide adequate care for their own children. An understanding of the powerful unconscious processes in operation more effectively gauges the risk factors that such parents present. However, such cases and enactments on behalf of parents can be bewildering to social work practioners. This may potentially lead to the social worker feeling persecuted during the process, resulting in impulsive, unprocessed and poor decision making despite their best conscious intentions. To mitigate these challenges there is discussion of the support needs required for social workers, who engage with such complex unconscious dynamics.

Introduction

Social workers are often required to manage complex relationships with vulnerable and challenging service users and this is exacerbated during often adversarial court proceedings regarding the welfare of children and the rights and needs of parents (Stevenson, 2012). More recently relationship-based practice has become an important aspect of social work education and practice (Ruch, 2005, Trevithick, 2003). Consequently, reflective practice and use of self have come to the fore and are central components in social work education. Students of social work are required to explicitly demonstrate the use of these components throughout their training, in terms of their social work competencies and standards of proficiency. The new Knowledge and Skills Statements (KSS) places relationship as one of the requisite skills required of social workers (DoH, 2015), in line with the Health Care Professional Council (HCPC) which is the current registration body in the UK for social work accreditation.

This article discusses how psychodynamic theory and psychodynamic principles can act as 'interpersonal tools' to enable social workers to more effectively navigate relationships with the most vulnerable service users. This entails a consideration of the support needs of such service users and the essential, but nonetheless anxiety-provoking, assessments of potentially high risk and vulnerable service users with whom social workers have frequent contact. These essential social work tasks need to be carefully managed, whilst also remaining sensitive to the risk of social work burnout and defensive practice in the on-going face of human suffering (Berzoff and Kita, 2010). Such burnout and defensive manoeuvring has contributed to disastrous

outcomes for vulnerable service users and the reputation of the social work profession historically (Munro, 2011, Cooper and Lousada, 2005, Cooper, 2005).

Psychodynamic Notions of Mental Health

There is a need to understand what motivates human behaviour and an acknowledgement of both external and internal processes. Psychodynamic concepts and formulations deepen the understanding of what it means to be human and to understand human distress and responses in terms of how people attempt to manage painful anxiety by defensive manoeuvring

Many notions of mental health are, however, culturally specific and can change over time (Marsella and Yamada, 2000). However, the need to relate is innate, beginning in our very earliest days (Stern, 2000). According to Freud an indicator of good mental health is the ability to love and work (Freud, 1925). This still has relevance today in terms of the service users with whom social workers often come into contact; many struggle in their personal relationships and to maintain stable lifestyles, including employment and the capacity to care for their own children.

Melanie Klein's (1959) notion of mental health includes the ability to maintain the "depressive position" for a significant amount of the time. The depressive position requires the internal capacity to view the world in a balanced way, without needing to split relationships in terms of those we love and those we hate, and instead recognising that most people are far more nuanced. The ability to relate without becoming too enmeshed by projective processes with others is an essential developmental achievement. This is to see people and experiences more realistically and not excessively, based on our unconscious expectations of them.

The Social Work Context

The service users who are often involved in statutory services and who come before the courts tend to be the most vulnerable, requiring the involvement of multiple agencies (Evans, 2016). The social worker, therefore, needs to understand how the service user's context responds to them and how they respond to their context. These responses can be highly indicative of the service user's state of mind, providing invaluable information for how best to engage the service user. Only seeing the individual service user in isolation risks the social worker developing a potentially skewed view of their difficulties and the location of intervention required.

An understanding of unconscious phenomena and defence mechanisms by the social worker when working with their service users can enable a more effective strategy to be developed to manage complex phenomena. The strategy can enable the social worker to operate beyond the surface and with a greater understanding of their unconscious processes in their interaction with service users. The interaction, therefore, between service user and the psycho-dynamically informed social worker

has the potential to be more sensitive to what may become enacted between the social worker and the service user.

The more common defence mechanisms include projection and projective identification. These are based on the premise that people have tendencies to attribute negative aspects of themselves to other people. Such projection disavows what they need to acknowledge to gain a better quality of life via greater psychic health by addressing rather than denying destructive aspects of themselves (Klein, 1959). Additionally, an understanding of the notions of transference and counter transference are essential in psychodynamic theory.

The more destructive and dysfunctional defences include a tendency in people to repeat or re-enact in their relationships with self and others' traumatic experiences that they have been unable to manage. This is known as the 'repetition compulsion' (Loewald, 1971, Freud, 1920); and an identification with the aggressor (Ferenczi, 1949), which is to take on the attributes of those who have caused harm and is illustrated in the case study below. These are unconscious but are nonetheless powerful dysfunctional defence mechanisms, requiring recognition and skilled management to mitigate their destructive potential.

An ability to think before acting in a reflective manner is an essential requirement for social work engagement. A more vulnerable service user may deploy projective processes much more aggressively. This means that those on the receiving end of such projections are impacted far more forcibly and will require the necessary skills to manage powerfully organising projections and projective identifications. Fundamental to a psychodynamic approach to social work is the ability for the social worker to think about difficult, uncomfortable and painful feelings invoked in them and view them as communications that can be responded to in the right way and at the right time. This is no easy feat, particularly in the face of service users who may be in crisis and who may be demonstrating distressing and destructive behaviour. The reflective practice required from the practitioner in these contexts is to disentangle their own feelings, based on prior history, from those of the service user. In this way, they create a space of empathy, thereby avoiding over identification and enactment (Hinshelwood, 2004, Evans, 2016).

Psycho-Dynamics and the Role of the Contemporary Social Worker

The role of a contemporary social work is an increasingly complex one, requiring the social worker to skilfully traverse a number of highly challenging social phenomena, societal structures and cultural assumptions as well as powerful unconscious forces. Effective social work practitioners require an understanding of both external and internal phenomena to an enable an ability to manage the balance between thinking, doing and being as a basis of the 'use of self' as a resource that they offer.

Social work practice takes place in the context of several powerful discourses (Stevenson, 2012). The most powerful is legal discourse; social work practice is

predicated on the principles of legal discourse, both criminal and civil. Thus, social workers are required to navigate and manage the potential conflicts, for example, between these discourses, the rights of parents and the welfare of children. This is, therefore, a complex terrain which the social worker needs to navigate as many of these discourses are, indeed, in conflict. The complex contexts in which a social worker needs to organise a strategic response to the service user cannot be over-stated (Stevenson, 2011).

Such a daunting task requires a clear theoretical framework as a basis for the social worker to methodically plan and deliver each step in the social work activity. A well thought out theoretical formulation is an essential element of an effective social work strategy and a basis for the relationship with the service user. This formulation needs to be mindful of the service user's predicament, the role of the social worker in the context of their agency and the policies, procedures and ethos of the community at any given time.

Risk, Trauma and Abuse

Corbett (2016) describes trauma, *"As a bomb that detonates nearest to the survivor which also explodes into those around him".* This extends to the social worker and clinician. It is vital that the social worker understands some of these processes and accesses the necessary support and supervision to manage complex and distressing emotions.

Attempting to make emotional contact with a troubled state of mind is challenging for both the practitioner and the service user alike and may be resisted by both. Additionally, a response to the service users' concrete demands, obfuscates an opportunity to understand their more latent anxieties and the risk they pose to themselves and others. Overall, a service user's behavior can be best managed if the practitioner is able to allow themselves be emotionally impacted by the relationship they have with their service user, whilst maintaining enough distance to enable reflection during the process (Gutheil and Gabbard, 1998). This enables a more balanced view of the service user.

Winnicott (1947)) described the concept of, "Hate in the counter transference". This extends to the difficult and negative feelings a social worker needs to manage and contain in relation to the challenges posed by the service user. This replicates experiences of early childhood, when 'the good enough mother' (Winnicott, 1960) has to manage her negative feelings due to the demands made by her infant child, which risk acerbating her more negative feelings, instead of acting on these feelings. This is the basis of the 'holding' (Winnicott, 1960) and 'containment' - the ability to metabolise and send back difficult feelings in a modified form of communications - as opposed to the realisation of unprocessed reactions (Bion, 2013), which are taken into relationships in the future. This includes, from a psychodynamic perspective, the relationship between a social worker and a service user within their specific context.

Many service users will have been extremely traumatised and will not have experienced 'holding' and 'containment' at traumatic times in their lives. Such service users will require their social worker to have a mature capacity in order to manage the service user's more complex feelings towards them in times of crisis. If the engagement is successful, it can be deeply reparative. Alternatively, should the social worker become overwhelmed and caught up in a re-enactment of the response of a previous care giver, there are risks of re-traumatisation of the service user. Negative social worker reactions include poor decision making, retaliation toward the service user or withdrawing emotionally if they are made to feel like a failure. Such reactions to the service user can be significant and dramatic often pulling the social worker unwittingly out of their boundaries and into enactments of internalised dynamics that mirror the patient's experiences and unconscious phantasies. Social workers, who possess limited understanding of unconscious processes, may be more vulnerable in this regard. This is illustrated in the following case study.

Case Study - Assessment of a Female Service User in Court Proceedings.

Ms H is a 35-year-old white female who was referred to me for a community-based parenting, risk and psychotherapy assessment. The proceedings related to her two youngest children. Her first child had been removed eight years previously and placed for adoption due to severe neglect, witnessing chronic domestic violence and being sexually abused by Mrs H's then partner.

Ms H has a history of sexual abuse and severe neglect, chronic depression, anxiety, occasions of psychosis and a diagnosis of borderline personality disorder. She was prescribed anti-psychotic, anti-depressant and anti-anxiety medication. However, her overall compliance and engagement regarding her treatment was inconsistent. None of her family members had spoken to her for several years due to the allegation of sexual abuse she made against her father and brother and the fact that she had lost her first child due to neglect and sexual abuse. When her next two children were later removed from her care, her 'non-abusing' family had cared for them, contributing to them not being placed in foster care. With support, Ms H began to make progress; she was compliant on medication and was accessing therapeutic support in a voluntary mental health organisation. Mrs H was consequently reassessed and the children were returned to her care.

However, within twelve months, matters deteriorated and the children were again removed from her care due to neglect. The children were described as being filthy dirty, with long-standing untreated head lice, matted hair, poor school attendance and were of a generally dishevelled appearance. I gleaned from the records and reports that the children's services department social workers were clearly very angry and felt betrayed by Ms H. They felt that they had given her many chances and returned the children to her care, for the children to suffer again from neglect, emotional abuse and suspected sexual abuse from a man who had previously been accused of sexually abusing other children in the area; a fact which was known to Ms H. Ms H had undertaken not to let the children have any contact with this man but

had subsequently allowed him to take the children to school on the rare occasions that they attended. On this occasion, the same family members who had previously been supportive, refused to look after the children and declined all contact with them and Ms H. The children were, therefore, placed in foster care.

At the time of my instruction, there had been a breakdown in Ms H's relationship with children's services. Her legal team had persuaded the courts to instruct an independent assessor. Matters had become highly acrimonious between the legal teams, the mother and children's social services. The social workers who had made the first assessment were no longer working within the department, so they were not available to liaise with me. I was, therefore, only able to infer the thinking and unconscious processes underpinning their attitude to the family by reading the assessment reports and by noting the decisions made. I was also explicitly directed not to have contact with the current social worker given the level of acrimony between the parties; central to my instruction was that I must be independent of children's services.

When I met with Ms H, I was immediately concerned about the condition of the accommodation. Upon entering the home, I had an intense feeling of wanting to leave due to the atmosphere and condition of the home. Ms H alleged that she been treated unfairly. She described an isolated and lonely lifestyle with no visitors. I was struck at the poor and empty quality of her life and the complexities of a considerable needs. I felt gravely concerned about Ms H, particularly in relation to her isolation. Throughout the meeting, she made very little eye contact with me. She seemed sensitive and very fragile. I had a strong sense of being in the presence of a frightened little girl. In relation to counter–transference, I experienced a sickening feeling of being powerful and potentially abusive. I wanted to leave the home as soon as I arrived and when I did leave, my relief was only short lived, as I was aware that this was only the first of several home visits I would need to make for the purposes of the assessment.

It seemed indicative of the pain of working with Ms H, that the current children's social worker had never visited the family home in the seven months she had been allocated the case. This could be considered poor practice, leading to criticism of the social worker. However, I consider this indicative of the lack of the necessary specialist support and supervision made available to any social worker who is expected to work with a parent who presents such complex psychological needs, in a very acrimonious legal context. In my experience, criticism and blame of the social worker is a frequent outcome.

During our meeting, I was concerned to hear from Ms H that she had a new partner, whom she had met on social media. She told me that he had just contacted her out of the blue and he was not a friend of anyone else she knew on social media. She advised that she had not questioned why he had selected her on the website and confirmed that he had pictures of her and her children. He lived some distance away; she had met him at his house on four occasions and she felt that the relationship was becoming serious. Ms H informed me that the children had not met him as they were in foster care but had spoken to him on the phone and they were

forming a relationship with him. This immediately raised concerns for me but did not seem to do so in Ms H.

I asked her if she thought Social Services were correct in removing the children from her house. She said, *"The first time the place was a proper dump. The children were not attending school. My ex-partner was in their life at the time and this was not a good relationship."* She said she had not been in a good place because she had come off her various medications. She had forgotten to take them, as she did not like the side effects. On the second occasion that the children were removed, she told me that *"Social Services were too quick to judge and the children did not want to be removed from my care. They were in tears when they were taken."*

When reflecting on the man she had met on social media and with the removal of the children, I was left feeling that, in addition to my concerns about the welfare of the children, that I was taking part in a process of depriving Ms H of what little she had in her life. This left me feeling conflicted and reinforced my desire to withdraw from Ms H, which seemed to replicate her family's experience and her more recent experience with children's services.

The theme of not taking very important medication and this having a very damaging effect on her life and her ability to care for her children was one which recurred throughout the meetings. There had been three occasions, including more recently, when she stopped taking her anti-depressant medication and had slumped into depression; and another occasion when she had stopped taking antipsychotic medication. All of these omissions had serious implications for her ability to care for the children.

I wanted to understand why Ms H was inconsistent in her use of her essential medication and why she had let matters deteriorate again for her and the children. Instead of becoming angry and frustrated with Mrs H for, yet again, neglecting her children and, indeed, exposing them to risk of, or even actual, sexual abuse, I needed to reflect on what was being communicated about Ms H's internal world that was being enacted in her present relationship with her children and professionals. It appeared that children service's acted in a similar way to that of her 'non-abusing' family by becoming angry and frustrated with her, by feeling betrayed, and ultimately seemingly by withdrawing their support.

Clearly, Ms H was in no position to resume the care of the children. There was a conflict on a manifest level between Ms H as a parent and her own considerable needs. These needs related to her own trauma and abuse, as well as the welfare of the children, who due to her inadequate care had also suffered trauma and abuse. Considering a victim/perpetrator dynamic (Gutheil and Gabbard, 1998, Corbett, 2016), I was simultaneously concerned with Ms H's manifestly passive, depressed, victim persona and the latent, perhaps very angry and vengeful woman, due to the abuse and trauma of her own life, unconsciously leading to her trauma being re-enacted with her children (Welldon, 2011, Motz, 2016).

Ms H seemed to demonstrate an example of one of the dysfunctional defences called 'An identification with the Aggressor' (Freud, 1936, Ferenczi, 1949). This is a dysfunctional defence against the knowledge of the pain of previous trauma that comes at great cost by exacerbating personal difficulties, often deployed by people who have been victimised and traumatised in their own lives in an attempt to master unprocessed trauma where 'childhood trauma has been turned into adult triumph' (Stoller, 1986). This is a significant driver for the intergenerational transmission of trauma and abuse.

In addition to Ms H's manifest depression and anxiety, it is important to understand some of the unconscious and perhaps more destructive aspects surrounding Ms H if she is to be effectively helped and that the risk she exposes her children to is assessed accurately. Evidence of this is that, more recently, she has not only allowed the children to suffer yet again a period of extreme neglect, she has exposed them to at least one more possible sexual offender.

Miss H's personality structure is, therefore, highly complex and requires sophisticated understanding and management. Exclusively seeing her as a victimised and lonely woman, who she indeed is, also does not give a sufficiently dimensional impression of the specialist input she requires. I questioned if this was the case with the children's services department who prematurely returned the children to their mother's care. I questioned if they were unconsciously organised by Ms H's projection of emptiness and desolation that could only be remedied by return of the children. Had the social workers returned the children prematurely and re-exposed them to further abuse and trauma because they had been unable to manage the complex feelings projected into them by Ms H?

Such projective identification can be powerfully organising. Even the most experienced professionals, who do not have an understanding of such phenomena, can find themselves responding to the manifest needs of the service user in a concrete way. They are consequently organised in ways that are not helpful to the service user, and in this case especially, the children were returned prematurely to their mother, only to suffer further abuse and neglect. When the social workers realised that they had been manipulated and betrayed, albeit unconsciously, they reacted in a punitive way, which was a re-enactment of Ms H's history of abuse and betrayal. This stemmed from a lack of understanding of how complex Ms H's difficulties were, and continue to be, and how these difficulties presented.

My feelings of guilt and responsibility about Ms H's predicament and her manifest wish to have the children return as a remedy to the bleakness of her life, required an understanding of projective processes. However, in my opinion, Ms H's needs were manifestly in conflict with the needs of the children. I, therefore, needed to manage my counter-transference in relation to Ms H during the assessment process. This entailed my feelings of wanting to withdraw from her and to express my frustration at her very obvious errors leading to the harm suffered by the children; as well as her seeming oblivion to further risk of sexual abuse. However, an understanding of unconscious processes, especially projective identification, the repetition compulsion and an identification with the aggressor enabled me to understand the

complex psychological dynamics that Ms H was caught up in, of which she had very little insight. This enabled me to manage my relationship with Ms H more sensitively and with more empathy during the assessment process and in line with child protection principals, which places the children's welfare at the centre of any recommendation and decision making.

Providing the children with the care that she never received herself but so greatly craved, was perhaps too great an undertaking for Miss H. The situation elicited a powerful and envious response, potentially fuelled by resentment of the children as they were potentially receiving the support and care that she did not; a situation which prevented her from providing the children with a consistent standard of care. This is an important factor that would need to be addressed in any psychotherapeutic work with Ms H. This work would be in addition to any unconscious identification she has made with her own family, specifically her parents, who betrayed her and by whom she was either sexually abused or failed to be provided protection from. These feelings of betrayal were re-enacted in her relationships with Social Services and with her children.

An understanding of both Ms H's more vulnerable and destructive aspects, albeit unconscious, would hopefully lay down the foundation for her to engage with the input that she so desperately required. I recommended that Ms H's own profound therapeutic needs were incompatible with her capacity to care for children within a reasonable time scale. This was a different response from the previous social workers who, by not considering her more destructive, unconscious processes, unwittingly re-enacted her family dynamic by acrimoniously withdrawing from her, leaving her abandoned and alone, punished for her failures and without insight into the extent and implications of her difficulties.

Psychodynamic Reflective Spaces for Social Workers

Social workers are employed in a range of social care organisations. Some organisations, such as, Child and Mental Health Services (CAMHS) and adult psychotherapy departments attached to Community Mental Health Teams (CMHT), often require additional psychotherapeutic training for social workers. However, community-based social workers, who have not had the benefit of formal psychotherapy training often still find themselves working with service users who present such complex issues. Emotionally, this is extremely demanding, often pulling social workers in different directions. On the one hand, having to manage feelings of guilt and possible omnipotence and the care and control function of their tasks on the other. Often this happens in the context of great vulnerability to the family and also, to the social worker within adversarial and persecutory court proceedings. There are clearly powerful structural, organisational and psychological obstacles, which potentially overwhelm social workers who attempt to assist service users in the face of such emotional bombardment and often institutional lack of support.

In the context of the challenge that such cases present to social workers and their vulnerability to blame or unconscious feelings of guilt, sophisticated support is required for social workers to manage and traverse complex, unconscious

phenomena, to enable them to manage their tasks effectively. I had the advantage of my training in psychoanalytic psychotherapy and access to psychodynamic supervision and reflective space, which enabled me to avoid the pitfalls of the previous social workers when working with Ms H.

Although extensive additional training is not often available for social workers they can still greatly benefit from a psychodynamic understanding of social worker/service user dynamics, through the use of psycho-dynamically informed supervision and reflective spaces (Stevenson, 2015, Hingley-Jones et al., 2016). Such support groups and supervision can provide social workers engaged with such complex services users with the structured, reflective support required to process their own responses to such cases. This has the potential to provide the environmental essentials (Stevenson, 2015) to enable social workers to understand and manage the impact on them of working in such a challenging terrain. Thereby, assisting them to make more processed and balanced interventions and decisions, whilst at the same time, reducing burnout and occasions of blame.

Psychodynamic Formulation

A psychodynamic formulation has the potential to enable a better understanding of Ms H's needs and how they were re-enacted and has a greater likelihood of leading to a more rounded response. According to psychodynamic principles, past trauma often repeats itself in the present. It also helps us to understand how the service user may be afraid of making progress and letting go of bad internalised objects and representations of previous caregivers and relationships. Although these dysfunctional defences and internal objects proffer a sense of psychological balance on one level, they come at great psychic cost.

Both the manifest and the latent require essential consideration during a psychodynamic social work assessment. It is a sensitive undertaking to consider the conflict between the rights of parents and the welfare of the children during such an assessment. As a social worker, I wanted to assist Miss H, whilst at the same time, managing my feelings of not wanting to deprive and traumatise her, which had been her experience of her family and previous professionals

Clearly Miss H has been severely victimised and abused throughout her life, from childhood extending into her adult relationships. It is, therefore, important to acknowledge those aspects whilst, at the same time, recognise her sense of self has been shaped by her abusive and violent upbringing. This included sexual abuse and an identification with her aggressors, which has significantly contributed to the harm done to her children. Holding these two aspects of Ms H in mind is a delicate task for the social worker, or any subsequent clinician. However, a failure to do so risks neglecting to address an important aspect of Ms H's personality and the risks that she poses. She omitted to care and protect her children, exposing them to high risk individuals; additionally, she failed to take her medication and to attend a therapeutic resource. This could indicate great hostility toward her children in a

deeply unconscious way, thereby, repeating the abuse and neglect she experienced from her own parents.

Conclusion

My assessment concluded that Ms H was unable to provide a nurturing environment for her children. Her own unmet needs are considerable and overwhelmed her capacity to care for her children. A psychodynamic formulation of Ms H looked beyond the surface phenomena of her life, which indeed is considerably bleak. Just to be satisfied with a surface phenomenon is insufficient without an exploration of the unconscious phenomena in terms of what is communicated and re-enacted. A psychodynamic understanding can assist the social worker to engage with the internal and external world of the parent, to enable effective intervention and safer recommendations to the courts.

Being mindful of unconscious dynamics, which may have contributed to the trauma and abuse they may have inflicted on their children and acting as a powerful driver for the intergeneration transmission of trauma and abuse. An effective psycho-dynamically orientated social worker needs to traverse a complex terrain of internal and external reality, between the individuals they assess and their context, which includes any potential conflict between the psychotherapeutic needs of the parents and the care needs of the children. Psychodynamic theory provides the social worker with the interpersonal tools to manage complex relationships between the most vulnerable service users within the chaotic and turbulent organisations and environments in which they often inhabit.

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