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Parental responsibility

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One of the main concepts in the new Children Act (1989) is that of parental responsibility, which will significantly alter the practice of family law and that of mental health professionals dealing with the troubled family. Instead of an assumption that parents have absolute authority over their children, there is the notion of a partnership between parents and children, with the power of the parent decreasing as the child grows in maturity and understanding. There is an emphasis on partnership between parents and those who will have to share in having parental responsibility when it has broken down. Thus the new Act is essentially child centred. It affirms the principle, current in Wardship proceedings, that the child's welfare shall be the court's paramount consideration.

In this paper I am concerned with some aspects of how the new legislation may affect the practice of mental health and legal professionals dealing with those severely disordered families who find themselves giving up their parental responsibility, or who have great problems in exercising their parental responsibilities. My account is based on the extensive experience of assessing and treating such families, many of whom have suffered from child physical and sexual abuse, in the Family Unit of the Cassel Hospital. Details of the treatment programme and the principles of working within the legal framework have already been published (Kennedy *et al*, 1987; Kennedy, 1988, 1989).

I wish to examine three main aspects of parental responsibility: what do we mean by parental responsibility, how do we assess it, and how do we promote it in severely disordered parents? I suggest a broad definition of parental responsibility which can then lead to a scheme for assessing the quality of parenting, which may help professionals make decisions about a child's future, and may also help them work alongside parents who tend to give up their parental responsibility.

What is parental responsibility?

The new Children Act defines parental responsibility as "all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property", (s. 3[1]). However, what these rights, etc. consist of is not stated because the list would be constantly changing to meet different circumstances. I believe that there is a need to be more specific in order to devise a focus of work around each problem family, even if definitions have to change as society changes. In order to build up a picture of parental responsibility, it may help to look at families whose parenting has gone wrong, at theories of human development, and at the social context.

With the troubled family, one can see how parents may wish to give up their responsibilities to professionals and ask for parenting for themselves. They may give up their children, or be tempted to do so, even when treatment is offered. They may fight off attempts to help them, or may feel that they cannot take responsibility for their children for a whole day. Furthermore, the responsibility of parenthood may provoke a breakdown in the parents' functioning, making them unsafe for their children. Some parents may be very confused about how much responsibility they take for their own emotions, i.e. how much should be kept strictly between adults, and how much spills over into the children. Such confusion may result in physical, sexual or emotional abuse of the child.

One may see how the problem parent is unable for part or all of the day to respond to the child's emotional and/or physical pain; they may only see the child's pain as an attack on themselves. A parent may have unusual perceptions of what the child experiences. For example, a man, who had been involved in physically abusing previous children and was in treatment in the Family Unit with a new child, was terrified when this toddler messed its nappy. The father perceived the act as a rejection of himself, but he also identified with the child. He saw the toddler's lack of bodily control as akin to his own lack of control when he had abused the previous children. What had changed was that he was able to tell staff what he felt rather than use the child to act out his fears. Other pathological situations include when the parent may envy the child his own childhood; they may turn to the child for warmth and comfort, that is for parenting for themselves, or they may see a particular child as the source of all trouble in the family.

One could see these examples in terms of varying degrees of breakdown in parental responsibility, in

which the child's needs and interests come second to the adult's needs.

Theories of human development stress how the relationship between parents and children changes as the child grows. It appears to move from one in which there is absolute dependence on the child's part to relative dependency; or from 'primary' ties to the parents to a situation in which these ties are loosened over time. As the parents' responsibility for their children changes, so does the children's responsibility for themselves. That is, there is a constant and shifting relationship between the parents' and the child's responsibilities. A responsible parent probably needs to recognise these shifts.

Theories of human development have their own theory of human agency, concerning reasons for actions and the nature of personal freedom. For example, each theory tries to address how much freedom a child has, or should have, in relation to its parent and what are the degrees of such freedom. Probably most theories would agree that as the child grows up, there is a need for the caretaker to allow the child increasing freedom within a reasonably secure environment. There are also the difficult questions about how much freedom to act children may be allowed, how parents may foster children's freedom to think while at the same time offering limitations on their freedom to act, and the issue of how parents can allow children freedom and a life of their own, by offering them some kind of model but not totally living through their children. There is a need for parents and children to be actively negotiating the issues, at least when the child is of an age to understand notions of responsibility.

In the social field, apart from the fact that notions of family life are constantly changing, one could say that the family is usually organised around such everyday social events as eating, sleeping and working. Such events, ritualised and structured to a varied extent, provide the emotional context that drives practical life. Although apparently trivial, they form common human intercourse and provide the basis for mutual recognition and intimacy. However, in disturbed families, these activities, which have to be worked at continually, may become charged with emotion and conflict, and this may lead to the breakdown in continuity and consistency of daily life, which can lead eventually to destructive acts such as an attack on a child. Putting together the above points, I suggest that parental responsibility consists of a number of conditions.

The parents need to provide a reasonably secure physical environment for the child, given limitations of income. They need to have the child's needs and interests to the forefront of their thoughts and actions; to allow the young child to be dependent on them, and to allow the developing child increasing freedom and autonomy. They need to appreciate the child's world, with its need for good enough physical and emotional security, reasonable flexibility, appropriate disciplining which does not lead to physical abuse, warmth and understanding, on a daily basis. Parental responsibility involves taking personal responsibility for one's own emotions as an adult, not exposing the child to adult sexuality, which may lead to sexual abuse. It implies accepting the reality of the child as a separate life developing in his or her own way, but needing guidance and some structure. Parental responsibility also involves recognition of the need for the child his or herself gradually to take on more responsibility and that there is a shifting relationship between child and parental responsibility.

Assessing parental responsibility

A main criterion for assessing parental responsibility is the capacity of parents to take appropriate responsibility for their actions. If parents are constantly blaming other people, or 'over externalising' their emotions, directing their wrath at the courts, social services and the world for what has gone wrong in their family, the prognosis for change is probably poor. It may be difficult to be precise about degrees of responsibility, but the capacity of parents to own up to their thoughts and actions sets the tone for any detailed assessment of a parent's parenting and involves recognising that children need to be allowed responsibility as they mature.

In assessment of parental responsibility, one will be looking for:

(a) adequate provision of physical care, including being physically present for the child. This is usually the easiest capacity to assess, but may not be a reliable indicator of parental responsibility. A child may have a comfortable bed, but an adult may be sexually abusing the child in that bed.

(b) consistency of behaviour and functioning with regard to the child. This will include providing appropriate boundaries for the child, respecting the child's world, perceiving the child as different from the adult and with different needs, and providing appropriate restraint of adult needs and impulses. It entails keeping the child in mind. But it also probably implies some capacity to function as an adult, to be able to socialise with adults and not expect a child to take the place of adults for the parent. One would expect the parent to have reasonable impulse control, not to expose a child to adult sexual behaviour, nor to expose the child to criminal, delinquent and destructive behaviour. If a parent cannot keep a child safe, then parental responsibility has broken down. For

example, if a parent is chronically drunk and allows a child to play on a window sill of an open window, then that child does not have a parent who can keep him in mind. Under this heading one could include states of mind which may impair parental responsibility to a greater or lesser extent, such as acute psychosis. Some parents may lose a capacity to be a parent temporarily due to illness.

(c) capacity to empathise with the child. One would expect the parent to be able to understand the child's needs and wishes. This implies not allowing the child to take responsibility for the adult. Emotional liability or emotional flatness in parents may interfere with their empathy for the children. The latter includes a capacity to put oneself in the child's shoes, to try to feel what the child feels. This is different from imposing what the parent feels on the child, or not allowing the child to have any sense of being separate from the parents.

In the assessment of empathy, one would look at how parents respond to a child's emotional and physical pain, whether or not they express love and concern or rejection and hate, and the degree of any ambivalence. With mothers and babies, one is particularly looking at the quality of the bond between parent and child, the capacity of a mother to keep the baby in mind for the whole day, and to provide adequate intense physical and emotional care.

(d) capacity for trust. A major indicator of parental responsibility is the parent's quality of relating, both as observed in the family relationships and in the relationships between the family and the professionals. A capacity for play may be an important indicator of a reasonable parent/child relationship as it may indicate sufficient trust and intimacy between the child and its parent. Woodenness in play, or totally confused play, may be indicative of poor parenting, especially when combined with one of the other criteria of parental responsibility.

It is also our experience that successful work with problem families depends on a process of trust developing between the families and the network of professionals. These are often families who have been enormously threatened by the possibility of experiencing in themselves feelings of vulnerability or dependency, with the result that their vulnerable and dependent children have been subjected to neglect or abuse. A useful indicator of parental responsibility is the degree to which the professionals feel that they have to take on responsibility for the child. If many professionals are working endlessly around a family in the hope that the family will benefit, and if the professionals are all feeling hopelessly drained, it is often the case that the family are not engaged in significant work with the professionals, who are in fact really taking over from the parents.

(e) historical factors. Many parents who have difficulties taking on parental responsibility have had deprived childhoods, and a number of them have also been sexually and/or physically abused as children. Never having been allowed to be children themselves, they have difficulty in taking on responsibility as adults for their own children. In addition, a number of problem parents have had a difficult adolescence, which has predisposed them to difficulties in coping with violence and depression. Historical factors in themselves may only indicate risk factors.

(f) behavioural criteria. From the above criteria, it may be important to focus on specific behavioural criteria of parental responsibility for each family under assessment. For example, it would be important to assess how the parents cope with everyday tasks such as eating, sleeping and playing with the children, and correlate their behaviour with emotional factors, e.g. one may look at how consistent and safe is such behaviour, how a parent perceives the child while they are engaged in an activity, etc.

Parental responsibility and treating the problem family

A main issue in treating the problem family is how professionals can encourage parents to take on parental responsibility while not taking over from them. It is particularly difficult for professionals to stand by while a parent is actively rejecting a child or is not relating well to a child. The professional usually wants to intervene and prevent the child from suffering. While this attitude is understandable, and may be essential, there may be times when it is just as important to stand back and allow the parent to discover, or re-discover, their parenting capacities. That is, the worker will give back responsibility rather than take it away. In treating disturbed families, there is a constant tension between the wish and need to intervene and the need to foster responsibility by not taking over. For example, a mother and her young daughter were in the Family Unit as the mother suffered from repeated overdoses and acts of self-mutilation, which made her potentially dangerous as a parent. She soon began to make the staff feel

helpless and confused, which mirrored her feelings about herself. She had a suicide plan which involved her car. She brought her car to the hospital, saying that she wanted it available so that she could use it to kill herself when she wished. She thus put us in a difficult situation. Were we to simply remove her keys, we would be treating her like a irresponsible child. Yet we also wanted to keep the keys in a safe place, at first with her nurse. The mother often complained that we treated her like a child, and yet she was often furious for us for not taking away all responsibility from her. Yet if she were suicidal we had our own *professional responsibility* to maintain e.g. by assessing whether or not she was actively suicidal. She was confused about how much she wished to be a child and how much she wanted to be an adult, and this made it difficult for the workers to think straight. In the end, we decided to face her with what she was doing to us and how she was evading her parental responsibility to her child. At the same time, we made sure she had a bed available in a psychiatric hospital so that she did not feel trapped by us into having to be responsible.

In order for the professionals to monitor effectively their emotional reactions to these families, they may need to be aware of the existence of the parental transference, that is how the parents will tend to experience the professionals in repetitive ways related to their own childhood experiences, seeing them as, for example, always rejecting, failing, cruel or indifferent, or confused and enveloping. Both professionals and patients may find themselves caught up in the illusions of the transference, so much so that there is a constant enactment of it, so that a professional may indeed become cruel and indifferent, etc. However, the professional may also experience the 'reverse transference' (see King, 1978), when they may be forced to feel what the parents experienced as children themselves. The anger and helplessness a worker may feel towards a parent may not only represent a parental transference reaction, but may also be a communication about what the parent felt like as a neglected child, angry and helpless with no nurturing parent. The worker comes to represent the parent figures from the past and the child in the patient. Sometimes, work with these families can only progress when the parents feel that they have communicated to a worker how helpless they had felt as children. It may come across to a worker as an attempt to deskill them, but it may really be a wish for that helpless child to be understood and recognised.

Treatment of families in which there has been sexual abuse poses particular problems for the staff because of the intensity of the emotions involved. The shock and horror, the wish to make someone pay for the abuse, the sense of innocence lost, make it difficult to see what can be done to help. Those parents who have been sexually abused as children may have dealt with these sorts of feelings in a variety of ways. In those who have also had disordered families, they may feel unreal about themselves and their bodies. They have split off the trauma of abuse in order to live, but at a price. Severe breakdown, either through having a psychiatric illness and/or through giving up their parental responsibility, may occur later in life, for example with the birth of their first child, or when their own children show signs of disturbance.

When these families are taken on for treatment, what may happen is that there is a repetition of aspects of the abusing situation. Although sexual abuse may not actually recur, there is an equivalent kind of abuse. Staff fears and fantasies multiply, workers feel used and abused, there are fears that professional boundaries cannot be maintained, the staff feel the strain is too much to bear, and there may be a wish to turn a blind eye to the seriousness of the situation, particularly in my experience when there is a child who has been homosexually abused. In turn, the family may feel increasingly unsafe and trapped in a situation from which there is no relief.

The staff have to be helped to go through a process in which they experience the anxieties concerned with sexual abuse, but then they need to be allowed to make sense of these anxieties. The process of taking responsibility for the treatment consists of at least three stages: first, they have to have the thoughts about incest, abuse, etc. and be allowed to be horrified; then, there needs to be a process of inquiry, of understanding and insight. Finally, they may be able to bear the pain of what has happened, and they may then be able to help the family deal with their guilt. As in treating other kinds of severe family disturbance, once professionals take on responsibility for what they experience, the families may begin to take back responsibility as parents rather than give it up to the professional network.

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