‘Can I sympathise with mothers who have hurt their children?’

Lauren Mountain never imagined this would be one of the first groups she worked with as an assistant psychologist

It was a familiar story: Naomi had experienced an emotionally and physically abusive past and unstable upbringing. She was on the child protection register. Moving between her separated parents from the age of four, Naomi had a series of less than desirable step-parents who were often neglectful or violent towards her. Throughout her therapy we heard about how her mum in particular had put her romantic relationships before Naomi… when those relationships ended they would go to a refuge to rebuild their lives again.

During her teenage years Naomi had a series of abusive relationships involving drugs and sexual exploitation; when she was 19 and in a relationship with a heroin addict she served a brief prison sentence for robbery. On release from prison Naomi quickly became pregnant with her first child. When he was just 10 days old, during an argument with her partner whilst trying to dress her baby, Naomi accidentally broke his arm.

Social services became involved and removed the child, who was put up for adoption. Naomi then became pregnant with her second child; they were placed in a mother and baby unit. Feeling under pressure, unable to manage her emotions and cope, Naomi ran away from the unit – leaving her second child there. Naomi had two more pregnancies. Both infants were removed from her immediately following birth in hospital.

This is not an uncommon story. The mothers we meet in our group often have a diagnosis of emotionally unstable personality disorder, and have had social services involvement, sometimes leading to those children being removed. Research suggests that victims of childhood abuse are at increased risk of abusing their children, and so interventions need to be designed to break this cycle of abuse.

This is where our therapy group comes in, using a mentalization-based therapy model. Members attend once a week for 18 months. These people may be cut off from their emotions, with chaotic lives. We have to work hard to engage them with therapy. Techniques include speaking with them on the phone prior to an assessment appointment, offering a number of assessment appointments if they do not attend, and a 10-week psychoeducational group prior to joining treatment. We have found that the ability to tolerate those 10 weeks is a good indicator as to whether someone is ready to engage in therapy.

In these appointments we will either hear very little about their children, or complete denial around the events that might have led to social services involvement; this could be a protective mechanism. Occasionally, if they share their experiences too early, they stop attending due to the shame of the situation – no matter how many opportunities we might offer.

Working with such a sensitive topic means that the relationship is key in facilitating change. Creating the safe environment allows the women to open up and think about their past and current behaviours. I believe that in order to break this cycle, at-risk women need to be engaged with as soon as possible; the help needs to be supportive yet challenging, and not accusatory or persecutory. In most circumstances women don’t want to hurt their children; even the most unimaginable situations.

From denial to acceptance

One of the most rewarding things is watching the transition from denial to acceptance. Whilst initially angry with external systems, in particular social services, the women begin to acknowledge how they might have let their children down. They get in touch with the complicated emotions that are evoked. They may have been detached from their emotions as a way of surviving. In the safety of the group they are able to reflect on the challenging situations they have been in and the factors that might have contributed to them acting in a certain way. They develop a language to be able to express how they are feeling, and to have compassion for themselves for the things they have been through in their lives. This helps them to think

about their own triggers, and warning signs that their mental health might be deteriorating.

We start to hear about their childhoods, how they feel that they had to look out for themselves with no adult or system looking out for them. Despite all they were going through, they were never taken out of the traumatic situation they were in. They may have done better than their own parents, but their best wasn't good enough. Saying that they don't want to end up like their parents is a sign that they are motivated to change. For me, this again highlights the importance of early support.

As psychologists working in the NHS, we often represent 'the system', so lots of conversations are had about trust. They describe desperation for help but not knowing where to turn prior to the social services involvement; afterwards they are offered treatment, but where was the help before when they might have been able to have their child with them? We encourage the group to be curious about why they think social services might have responded to each situation in the way they did, and avoid the persecution of other professionals. Group members further on in their treatment often manage to hold another perspective and get newer members to relate to their social workers differently.

Individuals might start therapy saying that they are doing so because 'social services told them too', yet after a while they begin to see the changes that they are making and realise it is for themselves. On completion of Naomi's treatment she was able to say that she understood that social services had the children's best interests at heart, and that if she was to have a child in the future she would work with social services to show how much she has moved forward.

Breaking the cycle

I can find the reality of my limitations difficult to accept. No matter how much work these women do in their therapy, it's unlikely to change the environment that they return to. We can only do so much. Early intervention needs to be improved in order to break the cycle. Referring women for therapy following social services involvement or the removal of their first child would make a difference. We often see women who have had their children removed becoming pregnant again almost immediately in order to 'replace' that child; Naomi is an example of this. It seems like this is a primal instinct; we don't work on it directly, but the group does allow women to become more mindful about having a baby, whether this be contraception, timing or allowing space to grieve for their loss.

One of the challenges in breaking this cycle is knowing where to start. Identifying these at-risk women is difficult, and I have wondered whether one option is a more intensive intervention for children who have been involved with social services themselves. There are great organisations such as Women's Aid and other women's community projects that work relentlessly with women in need of support but the resources can only go so far. Charities or other organisations are not able to directly refer into our service, meaning hoops to jump through before even getting an assessment. And there's perhaps a lack of communication or understanding about what is offered in different areas of mental health services, so it's difficult to know what is available for the people that we are working with in our Trust. Our group is one of only a few in the country; it feels like resources for this population are limited despite the severe consequences of lack of support.

Lauren Mountain

Systemic issues

I may have stopped working in this group, but these women and the experiences they have shared will stay with me for ever. Some may ask how I can sympathise with mothers who have hurt their children. Perhaps it's because it feels like it is a systemic issue rather than a 'personality' problem. The women have often worked hard to prove themselves (through case conferences, visitations or months in foster placements) or had their children removed. I'm not saying that their behaviour was acceptable, but we are working with them in therapy as they want to do things differently. Having seen a number of them complete their endings, to be able to think about whether they will have children again, what they will do differently and how they will work with the social services, gives hope that things can change.