Cultural and Ethnic Perspectives on Significant Harm: Its Assessment and Treatment

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The Children Act places a requirement to work in partnership with the families of children towards whom a service is being proposed, whether this service is one of assessment of need, of significant harm, of treatability, or of provision of alternative accommodation. The 'partnership' requirement applies regardless of whether the arrangement is voluntary, as in a Special Needs assessment, or involuntary, as would follow a Care Order. The concept of partnership implies that one so informs oneself that one can take the views of parents into account in making plans for the child. This is difficult enough in the adversarial context in which child care proceedings normally take place; it becomes doubly difficult when one is dealing with an ethnic minority family.

In this paper I shall attempt to address some relevant issues which may serve as practice guidelines. I am of Chinese ethnic origin and come from a traditional, hierarchical Singapore Chinese family. My early professional training was in Canada, and since 1979 I have worked in the UK as a Consultant in Child and Adolescent Psychiatry. The case examples used in this paper reflect my current practice.

When one is called out in and emergency to investigate an allegation of abuse, what does one need to think about? What is the worker's previous experience of working with ethnic minorities - is this 'coloured' by frustration and a sense of failure? How does one join or engage with these families, explore sources of strength and competence, look at the social and family context in which the alleged difficulties in individual or group functioning have given rise to professional concern?

Sources of strength, individual and family competence, are often to be found in the ethnocultural roots and traditions of the group. Religious belief, for example, often

provides a source of important cognitive orienting concepts by which the individual or group structures value systems, role relationships and expectations within the family. These belief systems and value orientations also provide a framework in which crises in life-cycle transitions can be successfully managed. Similarly, extended family traditions with ‘old fashioned' concepts of family honour, filial piety (where loyalties to parents take precedence over all other loyalties), and ‘reciprocal obligations’ which ensure an enduring network of kinship loyalties have in many traditional, hierarchical, families proved to be indispensable in ensuring family survival. However, conflict between traditional family values and those of more egalitarian, nuclear family structures may generate unbearable family tensions leading to family breakup, loss of morale and self-esteem, and abuse inflicted on more vulnerable members of the family.

In order to be able to assess abuse and the presence of Significant Harm in the different societal contexts found in the diverse racial and ethnic groups in the UK, one needs an appreciation of the range of this diversity, and the variations within ethnic groupings from traditional to modern/egalitarian. The author suggests it is important to start out with an understanding of one’s own ethnocultural roots and value systems. The worker from a family background with an egalitarian role model, and non-hierarchical relationships among the siblings as a valued norm, may find it difficult to work in a context where the father is the ‘head of 'the household’, as will be found in the majority of Asian and Vietnamese families; also special rights and responsibilities are conferred onto older siblings, especially the eldest son. Similarly, it would be difficult not to over-identify with the marginal adolescent who feels the only way she could protest against family expectations of an impending arranged marriage is by taking an overdose. It may be for the worker that the very idea of an arranged marriage is itself so odious that he/she forgets to explore other factors in family functioning where deficiencies may have led to the present crisis, for example, failure of mechanisms for conflict resolution and tension diffusion, or the presence of other serious problems like parental alcoholism or the existence of gambling debts.

The worker needs to be able to maintain a stance of professional neutrality, in order to facilitate and mobilise the family’s capacity to make choices instead of making decisions for them. Unfortunately, his/her normative assumptions about personhood

in a family may be interfering significantly with the need to be neutral. Also, in order to mobilize strengths based on ethnocultural roots, one needs to know what these strengths are before one can devise a strategy to mobilize them.

How then does one learn about these differences? Can and should one 'find out from the client'? In an emergency assessment situation, one is under a great deal of pressure to make judgements. It is however important to realize we all make judgements on the basis of what we think intuitively is right. The difficulty comes about when these 'intuitive judgements' are based on ethnoculturally defined values. This is compounded when the worker's only experience of particular ethnic groups is in the grossly abnormal context of an assessment under the Children Act. One then cannot depend on these highly disadvantaged and stressed clients, who may or may not be behaving in a deviant manner, to teach you about cultural values in their own community. One needs previous experiences with normally functioning members of that ethnic community, where one can see the cultural assumptions and practices with which one disagrees, operating within the life of that community.

In the spirit of true partnership, it would be helpful for the local authorities to discuss the question of significant harm and procedures for investigation and assessment with community representatives of the main ethnic minority groups in their areas. This may involve religious organisations or community associations and will enable valuable links to be established before crises occur. Aspects of communication, for example link workers, can then be addressed and community views ascertained, while misunderstandings can be clarified. Local authorities can then operate in a context in which they feel supported by elders from ethnic communities.

From a practical perspective I would suggest that the following findings would require immediate steps towards a thorough investigation, whether or not the worker was familiar with ethnocultural issues that may have a bearing on the case:

- the presence of actual physical injury;
- discrepancy between the child's account of events leading to the injury and the explanation offered by parents or caretakers;

- corroborative evidence from another agency with considerable opportunity to observe and report on the child's status, e.g. school nursery or day centre.

The following areas pose common dilemmas in the assessment of significant harm with regard to ethnic families:

- family structures that do not conform to Western European norms
- 'culture bound' symptoms
- culture-determined child-rearing practices

Family structures that do not conform to Western European norms

1.Single Parent Afro-Caribbean Families

Despite the rise in single parent families in the UK, the white one-parent family is still widely regarded as deviant from the Western European ideal. In the same way, society still views the family structure of single-parent Afro-Caribbean families as deviant. Studies of working-class family structure in the West Indies, for example Henriques (1949), clearly show the stability of the matricentred family grouping, around a consanguineous basis rather than a conjugal basis. Extended family links are often, built around the mother's blood relationships and a strong sense of kinship extends beyond the immediate mother-child unit, in working class families. Also, long established links albeit 'informal', as for example Godparents or Grandfather's long-standing cohabitee, may be invested with the same degree of authority and influence in family matters as the biological Grandparent in a traditional Asian family. Thus, for the single parent Black mother her links with her mother and brothers are extremely important. In father's absence, maternal uncle was often the most important authority figure in a young Black boy's upbringing.

2. Extended family groupings in the same household

The assessment and management of intergenerational conflict in the same household is often a difficult one for therapists from a Western European nuclear family structure. One needs to know what authority structure exists, and what rules govern role relationships and expectations of behaviour; and how the presenting problem is linked to the rules and beliefs.

Case example: An infant was admitted to a paediatric ward with a second head injury in 6 months. The mother admitted responsibility for both accidents, and said on the first occasion the child had fallen out of her rocker while rocking vigorously, and on the second she had been careless and the pushchair had slipped down the stairs with the child still in it while she was busy unloading the shopping. Paediatric staff reported the mother to be warm and attentive towards the baby in hospital, and appropriately involved in her care. We felt, however, that something was not quite right.

I asked to see the family, from a traditional Sikh background. They were initially unwilling to disclose 'private' family matters until I pointed out that their family honour could be involved. It then emerged that the mother was in an extremely vulnerable situation. This was a family where she was the only daughter in law to have come from Kenya, whereas the others were all British born. Being less conversant with British ways, she had accepted the role of being the family childminder for all the pre-school children in the family while the other women went out to work. In the mornings therefore she had been overwhelmed with the pressures of providing childcare to four children including her own baby and was also expected to do the shopping. Out of a sense of pride, and the need to prove her 'worth' to the family, she had not complained or asked for help from her sisters in law. A steep flight of stairs led directly to a narrow kitchen, and she had been putting the groceries away when her four-year-old nephew pushed the push-chair down the stairs. To complain about the behaviour of a senior sister-in-law's son would have been difficult, and challenged the hierarchy in the female network.

This family was helped to move from a position in which the young wife was being asked for a solution she could not give, to one in which the family could accept collective responsibility for protecting her and the children. The strategy was one of mobilizing family strengths through invoking the concept of family honour. Thus, the therapist respected and accepted the authority structure of the family and its rules, one. of the most important of which was the principle of inter-dependence.

Culture bound symptoms

Ethnic minority clients may present with maladaptive behaviour and symptoms influenced by the religious and symbolic language of the culture of origin. This may include a preoccupation with ghosts in incomplete mourning (Henriques, 1951); or spirit possession in conservative Muslim families or Chinese families from a rural background, often activated in a context of insoluble family conflict. Even though the symptoms and behavioural patterns may not fit established patterns of deviance in the wider British context, still the cultural patterning would be familiar to her members of the same ethno-cultural group and may not be seen therefore as irrational and inexplicable. The symptoms and behavioural patterns may conform to cultural expectations of how one gains entry to the sick role. For example, in Chinese communities depressed patients most commonly present with somatic complaints, and in the Chinese language depressed affects are couched with reference to the body.

Transient psychotic states in which the long-term prognosis is usually good, is also found more commonly by psychiatrist in patients from an ethnic minority background. This needs to be taken on board in the assessment of future parenting capacity.

Case example: An Afro-Caribbean mother was felt by attending medical staff to have made a good recovery from a stress induced psychotic state. She was still however anxious about her housing condition and despite support from Environmental officers, had not been re-housed. While in a psychotic state her symptoms had a marked sexual content. Her social worker refused to support her request to have her

children removed from the At Risk register on the grounds that she was still abnormally preoccupied with sexual matters and the children were therefore still at risk.

As a consultant to the system I was told by the social worker that on recent home visits the mother would talk incessantly about ‘cocks' and ask for help to get rid of them. She would also be abnormally concerned about the state of her children’s bottoms. The social worker was white and said the relationship with the mother was not a comfortable one, she was hard to understand.

I interviewed the mother on her own initially. There were no signs of mental illness. She had however a strong Afro-Caribbean accent. She said she had seen her social worker recently and, on each occasion, had tried hard to tell her there were cockroaches all over the place especially in the summer heat; and could not understand why she did not take her seriously.

I also saw her with her children, aged 3 and 5. At one point they had to go to the toilet and l encouraged them to go by themselves. After they had left the room the mother said she usually had to make sure they cleaned their bottoms properly. On the children’s return I inspected the bottoms. Neither child had wiped her bottom properly; the anuses were red and faecal matter was still present.

This was a case in which the social worker’s professional neutrality had been compromised by communication and relationship difficulties with the client. It also included a lack of understanding of the nature of transient psychoses. The social worker had been accused of being racist, which made her even more defensive.

Culture Determined Child-Rearing Practices

Given the importance of inter-dependence and family connectedness across the generations as a goal for the socialization of the young, it should not be surprising that patterns of child-rearing in traditional extended families would be different. The child from a traditional Asian or Vietnamese family may be sleeping with mother or grandmother for many years; indeed, co-sleeping arrangements are often preferred in

these families even though there may be adequate space for individual bedrooms. As the child grows up, he/she will have frequent. and regular contact with members of the extended family. Through regular participation in family rituals such as meals, outings, festivals, religious events, the child learns his/her place in the kinship system and the rules governing relationships, and expected behaviour. Thus, an older sibling will learn to take responsibility for a younger sibling; or to contribute to the family welfare by helping in the shop on the weekends. It will be a source of pride to 'so behave that your parents will be proud of you'. The young person learns the importance of maintaining the honour of the family by his or her public actions. Within the family boundary, he/she will also learn the importance of manoeuvres for diffusing tension in the family. Discipline is usually strict; the family cannot afford to lose: face in the community. A fuller discussion of the differences in family developmental tasks in traditional extended families is to be found in 'Psychological problems in adolescents from ethnic minorities' (Lau, l 990).

Refugee Families

Families with a refugee background will need to be handled with particular understanding for the traumatic stresses which have been part of the family's recent experience. Adults will to a varying extent carry features of Post-Traumatic Stress Disorder. For many, the stress of not being able to communicate in English will be extremely disabling, particularly for recent arrivals to this country.

Case Example: Two boys aged 5 and 9 were referred to a Child Guidance Clinic by the school with concerns for their 'cruel and sadistic" behaviour, which included pushing other children down the stairs. They had arrived in the borough some two months ago, speaking no English. The family were political refugees from a Francophone African country. Both parents had been victims of torture and mother bore obvious scars on her arms. The Clinic team met with the mother in her home with an interpreter. She said her husband was still in the country of origin and in prison. The boys did not know their father was missing and were told he was away on business. The mother described the boys as well-behaved at home and not a source of concern. We noted there were several letters offering health checks for the baby of

about 6 months that had not been responded to. The mother spoke no English and did not know anyone who could translate or interpret for her.

Several follow-up sessions were then unattended without notice. On one occasion we arrived at the house to find the children had been left in the care of the oldest child aged 10, who did not know where mother was. The children seemed calm and settled, however, including the baby. On a subsequent home visit, we found father, who had just arrived in the country after being smuggled out. He felt the need to be wary; there were likely to be death squads after him given his political status back home. He had clear symptoms of Post-Traumatic Stress Disorder, with recurring nightmares and somatic symptoms. When informed about the school's concerns his first response was to be angry and he threatened the school with litigation. At the same time the school was frustrated with the lack of resources available to help them with the children's language needs.

These refugee parents were particularly vulnerable on account of their refugee status and past experiences of overwhelming trauma and loss. These experiences, and distrust of bureaucracy, affected their capacity to negotiate with the school. Father's unreasonably threatening attitude at the school obviously reflected the violence of his recent past, as well as the family's bewilderment at the uncertain present. Mother also could not understand our worry about the 'children being left alone'. The missed sessions had to do With necessary trips to the Home Office which she had to keep secret as the discussions were about her husband. Also, the children were left in the care of the eldest child who she felt was adequate to the task. The children's behavioural disturbances were understandable in terms of their confusion at not knowing what was happening to their father, and at the same time realising something was upsetting to mother but could not be talked about.

Placement Issues

Given the massive over-representation of Afro-Caribbean and mixed-race children in care, discussion on placement issues of ethnic minority children has largely focused on the special needs of this group. There is currently considerable debate on

the same race versus transracial placement. issue, relevant to adoption and fostering. 'Tizard has questioned whether even the concept of a ‘positive racial identity’ is a valid entity, as current research has failed to demonstrate links with self-esteem. The Children Act however clearly says race, language, religion and culture need to be taken on board in placement considerations.

Case example: The adoptive parents of a 10-year-old boy of mixed race origins (White-Afro-Caribbean) complained of his ‘attitude’ problems. He would come home from school in a bad mood and get into an argument invariably with his father. Both adoptive parents were white, as was the other adopted child from infancy, a girl. Eventually on direct exploration he said it would be easier for him in his family if he were White, because he would not be called ‘Nigger’ by both his cousin and the boys in his school. He felt his parents did nothing about the racist abuse both within the family and outside it. The parents had told him it was just name calling’ and he had to learn to put up with it and not get into fights. I noticed that I had to draw attention to the racist aspects of what the parents referred to as ‘name-calling’ as they were anxious to minimize the racial differences between them. In fact, it became apparent that racial differences were not discussed. In time however it felt safer to do so and the parents appreciated their son’s particular needs for support for his racial identity within the family as well as the school. This led to a considerable improvement in the relationship between the boy and his father.

Case example: An adolescent girl of mixed UK White-Hong Kong Chinese parentage was placed in care following allegations of abuse. The girl was classified as Black, assigned a black social worker and placed with a Black family. In this case, the social worker as well as the foster family turned out to be Afro-Caribbean; The girl’s Chinese father found it difficult to think of his daughter living, as he put it, with ‘Black devils’. Issues of ethnicity and language had not been explored directly with the girl who had been exhibiting extremely disturbed behaviour, including wrist cutting and repeated suicidal threats, as it was felt by professionals involved this may precipitate further disturbance.

As a consultant to the network, I was allowed to interview the girl after I reported my separate interviews with the parents elicited the information that she had been a

fluent Chinese speaker. In fact, the mother had been enraged by the conversations between this girl and her father in Chinese as it excluded her. I interviewed the girl in Chinese, and it was clear she could understand what I said, though she was hesitant to reply in Chinese as she did not feel she could be sufficiently fluent. She said it was the first time for over a year that she had heard the language which she associated with the happiest period in her life, her early childhood spent with grandparents and extended family in Hong Kong. She showed me that she could still write her name and a few characters in Chinese. Over the past year no provision had been made to help her maintain links with the Chinese community, or to support her use of the Chinese language. She wanted to be able to read and write Chinese so that she could write to her family in Hong Kong. As they did not speak English, she could not otherwise communicate with them. She said she had not felt able to talk about any of this with either foster parents, social worker or psychiatrist, as they would not understand her wish to maintain a Chinese ethnic identity.

This case illustrates the difficulties in a professional system where the term 'Black' is applied to all ethnic minority groups, and thinking in child care derives solely from the paradigm of the historical conflicts between Whites and Afro-Caribbeans. It meant the child's ethnic identity needs, here tied in closely to positive hopes and aspirations for her future, were not addressed. An important therapeutic potential was therefore not mobilized.

In summary, I have found the following practice guidelines useful in the assessment of an ethnic minority family, and may facilitate the task of 'working in partnership'.

1. What belief systems and value orientations influence role expectations, define and set limits of acceptable behaviour? For example, traditional Islamic views on family life provide for segregation of the sexes, especially after puberty, with the expectation of chaste behaviour for adolescents and virginity on marriage.

2. What are the structures relevant to authority and decision making in the family? What are the kinship patterns? Which are the key relationships with

important supportive functions? What is the relevant family network? Authority structures vary between groups but in the traditional Asian or Chinese family the concept of head of household is still important and authority may be vested in the most senior male member; often the paternal grandfather. The kinship pattern may be that of the traditional extended family, with the expectation of reciprocal obligations providing the basis of interconnecting family networks.

3. What life-cycle phase is this family at? What are the risks and challenges? What are the traditional solutions used to manage conflict and to what extent are they operational in this family?

4. Where does this family fit in the range from traditional/hierarchical to modern/egalitarian? How is the living unit organised to enable essential tasks to be performed?

5. What traditional networks and activities (based on religious or family ritual) maintained and supported structural relationships in the family? Which of these have been lost, with what consequences?

6. What significant stresses and losses arise from the family's own experience, from the country of origin, from adaptation to the UK? What racial or cultural factors confer advantage or disadvantage to the individual/family in Britain?

For the traditional hierarchical Asian family the authority of the grandparents and a close network of relatives may have maintained a protective and buffering function for its members, enabling conflicts to be worked through before tensions rise to intolerable levels. For other groups the authority of the church, or other religious organisations, may have served similar needs. Immigration to the UK and the loss of these networks may have contributed to increasing helplessness, especially in vulnerable individuals, in an environmental context where new rules are not well understood and communication, particularly language, is poorly established.

A couple from a traditional, hierarchical extended family background who have just undergone an arranged marriage would be in the life cycle phase of early marriage. Unlike their counterparts in the country of origin, they may not have the protection of extended family networks around them. In the author's experience, brides coming to the UK to join their husband's family, without ready recourse to their own families of origin, may be particularly vulnerable. It would be crucial for such a bride to form alliances with the network of female in-laws. Her relationship with mother-in law would be especially important in determining her emotional survival in the extended family household, where initially she would be the most junior member in the 'family firm'. This often has implications for the emotional and physical well-being of children in the marriage. The reader is referred to 'Psychological Problems in Adolescents from Ethnic Minorities' (Lou, 1990). and 'Family Therapy in Ethnic Minorities' (Lou, 1988) for a fuller discussion on differences in life cycle issues for ethnic minority families.

Assessment and treatment responses to significant harm must be sensitive to ethnic and cultural issues and enhance the potential for building a working partnership with families and communities. Practitioners should consider two further points to achieve these goals. They should ensure that their clinical hypothesis takes account of the meaning of the symptoms and behaviour presented as deviant for the family, the ethno-cultural group and the wider social context, such as the school. They should also propose a strategy for intervention which attempts to mobilize strengths within a context that supports the authority structure of the family and community.

Bibliography

Henriques, F. (1949). West Indian Family Organisation. The American journal of Sociology. Vol 55 part 1: 30-37.

Henriques, F. (1951). Kinship and Death Jamaica. Phylon. Vol 12 part 3: pp 272-278.

Lau, A. (1984). Transcultural issues in family therapy journal of Family Therapy, 6. 91-112.

Lau, A. (1986). Family Therapy Across Cultures. Ln J.L. Cox (Ed.), 'Transcultural Psychiatry. London: Croom Helm: pp 234-252.

Lau, A. (1988). Family Therapy and ethnic minorities. In E. Street and W. Dryden, (Eds), Family Therapy in Britain. London: Open University Press: pp 270-290.

Lau, A. (1990). Psychological problems in adolescents from ethnic minorities. British journal of Hospital Medicine, V0144, September 1990: 201-205.