Syv sider ved samspillsadferd

1 Ansiktsuttrykk

2 Verbale uttrykk

3 Fysisk plassering og kroppskontakt

4 Uttrykk for positive følelser

5 Tur-taking

6 Kontroll

7 Valg av aktiviteter

OMSORGSSVIKTEDE BARNS BEHOV:

1. TRYGG TILKNYTNING UTENFOR FAMILIEN

2. BEARBEIDING AV OPPLEVELSEN AV OMSORGSSVIKT

3. KONTINUITET

4. MULIGHETER FOR Å PÅVIRKE SINE OMGIVELSER

FUNKSJONER\ MÅL I ARBEID MED BARN:

1. Å REDUSERE BARNETS INDRE KAOS - DELE SMERTEN

2. Å GJØRE LIVET MER FORSTÅELIG

3. Å GJØRE LIVET MERE FORUTSIGBART

4. Å HJELPE BARNET Å NYTTEGJØRE SEG TILTAK

5. Å REDUSERE BARNETS OPPLEVELSE AV ANSVAR OG SKYLD

6. Å SYNLIGGJØRE BARNET

7. SIKRE BARNETS "LIVING EXPERIENCES"

8. SORG - ERKJENNELSE

9. Å HJELPE BARNET TIL Å MESTRE

Hvorfor overser vi barnemishandling?

Det er legers ansvar å se og handle i barnemishandlingssaker, men de unnlater ofte å gjøre det. Det finn nok kunnskap til å se, undersøke og ta ansvar. Leger og andre profesjonelle anvender en rekke psykologi mekanismer for å beskytte seg selv mot å se.

Christoffer-saken og Alvdal-saken, der barn ble utsatt for mishandling, død og seksuelt misbruk, har berørt oss alle. I disse sakene var det ingen profesjonelle i skolen, sosialtjenesten eller helsevesenet som var i stand til å se, forstå eller handle. Barnevernet hadde ingen mulighet til å gjøre noe når ingen meldte fra. Heller ikke omgivelsene – det sosiale nettverket – gjorde noe for å stoppe overgrepene.

Det primære ansvaret ligger hos dem som ser barnet først. Ofte er dette barneleger, ortopediske kirurger, barnekirurger eller barnepsykiatere (1, 2). Er de bekymret for et barns omsorgssituasjon, har de meldeplikt til barnevernet. Dreier det seg om overgrep, har de meldeplikt til politiet. At dette ofte ikke blir gjort, kan skyldes for lang avstand mellom tilgjengelig kunnskap og de som skal anvende den i praksis. Profesjonelle (og ikke-profesjonelle) anvender en rekke psykologiske mekanismer for å slippe å se og for å slippe å ta ansvar (3, 4). Vi mener at undervisning om omsorgsvikt og barnemishandling vektlegges for lite i utdanningen av helsepersonell.

De profesjonelles motstand mot å se

At leger og annet helsepersonell har en motstand mot å se og handle, ble dokumentert i et prosjekt ved barneavdelingen ved Ullevål universitetssykehus i slutten av 1970-årene (5). Det ble også dokumentert at profesjonelle innenfor helsefag, sosialfag og pedagogikk bruker ulike mekanismer for å slippe å se. Dette er senere bekreftet fra studier fra andre land (6).

Det dreier seg om overlevelsesstrategier, overidentifisering med foreldrene, bagatellisering, rasjonalisering, distansering, projisering og problemforflytning. Ved overidentifisering tillegger vi foreldrene flere positive egenskaper enn de har, noe som hindrer oss i å se realitetene. Dette medfører ofte en bagatellisering av den fare barnet er i. Vi distanserer oss fra barnets sårbarhet, angst, lidelse og ensomhet. Ser vi noe som bekymrer oss, finner vi måter å rasjonalisere og bortforklare det vi aner. Vi kan distansere oss ved å trekke oss tilbake, henvise videre – «dette er ikke mitt bord» – og plassere ansvaret hos andre.

Står vi overfor et omfattende problemkompleks med samlivsvold, rus og psykiske problemer der barnet i familien har atferdsproblemer, er det lett å flytte oppmerksomheten over på barnets atferd. Christoffersaken er et godt, men tragisk eksempel på problemforflytning. Alvorlig omsorgssvikt og fysiske overgrep ble omdefinert til diagnosen AD/HD, og et aktivt arbeid med å undersøke relasjonene i familien og foreldrefunksjonene ble erstattet med medisinering (7). Slik slapp de profesjonelle å ta på seg den vanskelige og smertefulle oppgaven å ta innover seg Christoffers ensomhet og redsel. De slapp å forholde seg aktivt til foreldrene, barnevernet og politiet..

Ifølge Torleiv Ole Rognum, professor i rettsmedisin ved Universitetet i Oslo, skjer det hvert år rundt fem dødsfall som resultat av alvorlig vanskjøtsel, hodeskader eller kvelning (8). Det er godt dokumentert at fysiske overgrep er en vanlig årsak til hodeskader og bruddskader hos spedbarn (9–11). Langtidsskader er vanlig (12). Det er vist at blåmerker er en viktig markør for fysiske overgrep (13).

> «Emosjonell vanskjøtsel og psykiske overgrep er forløpere for fysiske og seksuelle overgrep innenfor kjernefamilien»

Kunnskap fra tilknytningsforskning

Barna har også sine overlevelsesstrategier. De beskytter sine foreldre. De vet det meste om samfunnets tabuer lenge før de har hørt ordet og vet godt hva den voksne verden ikke vil høre. Den tilknytningsforankrede samspillsforskningen viser oss hvordan spedbarn registrerer voksnes ansikter og holdninger og tilpasser seg de voksne. Det er god dokumentasjon for at emosjonell vanskjøtsel og psykiske overgrep er forløpere for fysiske og seksuelle overgrep innenfor kjernefamilien (14). Ved å utvikle en dypere forståelse av emosjonell vanskjøtsel og psykiske overgrep hos profesjonelle hjelpere kan vi ha bedre muligheter for å forebygge fysiske og seksuelle overgrep.

Vanskjøtsel har vært vanskelig å definere og å påvise, men forskning om tilknytning og samspill har gjort det lettere. Emosjonell vanskjøtsel handler om foreldre som ikke engasjerer seg positivt følelsesmessig i barnet. De er ikke følelsesmessig tilgjengelige, barnet har ikke noe samspill å gå i. Det er vanlig å beskrive to former for emosjonell vanskjøtsel. Den mest kjent er den som ses samtidig med ernærings messig, fysisk, materiell, medisinsk og sosial vanskjøtsel. Denne er godt kjent og kan ofte både ses og luktes. Den and formen er mindre kjent og kan være tildekket av overdreven dekning av ernæringsmessige, materielle, medisinske o sosiale behov (14).

Kunnskap fra hjerneforskning

Alvorlig vanskjøtsel er ikke bare skade for barnets fysiske utvikling, men også den psykiske (15). At proteintilførsel ti spedbarn er nødvendig for hjernens utv ling, har vært godt kjent lenge.

Nyere hjerneforskningen har vist at h nens utvikling også er avhengig av kva teten på den følelsesmessige omsorgen av kvaliteten i samspillet mellom forel og barn (15, 16). Følelsesmessig vanskjøtsel er en av de alvorligste trusler f barns fysiske, følelsesmessige, kognitiv sosiale og atferdsmessige utvikling.

Psykiske overgrep

Psykiske overgrep kan defineres som e kronisk holdning eller handling hos fore som er ødeleggende for utviklingen av positivt selvbilde hos barnet. Det lever en konstant bekymring for om foreldre vil være i stand til å ta vare på det og beskytte det og seg selv.

Dette dreier seg ofte om barn med fo eldre som har rusproblemer, er preget a voldelige samlivssituasjoner, psykiske lidelser og/eller forvrengte oppfatninge sitt barn, der barnet tillegges spesielle e skaper og behandles deretter. Barnet få vedvarende bekymring for det «forutsig bare uforutsigbare». Dette kan omfatte såkalte Münchausen by proxy-syndrom der barnet tillegges en sykdomstilstand behandles deretter (17–19). Alkoholmi bruk, rusmiddelskader og alvorlige psy sosiale belastninger kan være knyttet ti somatiske symptomer hos barn.

Både kunnskap og holdninger

Evnen til å se, forstå og handle konstruk i disse situasjonene handler om både ku skap og holdninger. Dette forutsetter n mer enn en veileder. Det er behov for b opplæring – ikke bare i diagnostikk av omsorgssvikt og overgrep, men også i eldresamarbeid, samarbeid med barna

tverrfaglig samarbeid. Det er behov for bedre retningslinjer om hvordan skole, sosialtjeneste og helsevesen skal identifisere og reagere ved fysiske overgrep, følelsesmessig vanskjøtsel, psykiske overgrep og seksuelle overgrep mot barn. Det trengs mer og bedre samarbeid og handling.

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Mottatt 6.8. 2012, første revisjon innsendt 10.10. 2012, godkjent 8.11. 2012. Medisinsk redaktør Petter Gjersvik.

Publisert først på nett 6.12. 2012.

Engelsk oversettelse på www.tidsskriftet.no

Pergamon

Child Abuse & Neglect, Vol. 20, No. 9, pp. 791–795, 1996

0145-2134/96 $15.00 + .00

PII S0145-2134(96)00066-X

INVITED COMMENTARY

HOW FAR HAVE WE COME IN DEALING WITH THE EMOTIONAL CHALLENGE OF ABUSE AND NEGLECT?

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Key Words—Emotional challenge, Abuse/neglect.

INTRODUCTION

WE ALL RECOGNIZE that we are working in an emotionally highly charged field. Surprisingly enough this aspect of our work and how to deal with it has not received much attention in the literature, either the clinical or the research literature. The attention it has received has mostly been related to the failure to report (Morrison, Johnson, & Clasen, 1989; Nightingale, & Walker, 1989; Sanders 1972). How it affects the professionals' daily work has received little attention. Copan, Krell, Gundy, Field, and Rogan (1979), however, identified 11 sets of feelings or conflicts which seemed to interfere consistently with effective delivery of care; anxieties about being physically harmed by angry parents and about the effects of a decision; denial and inhibition of anger, need for emotional gratification from clients, lack of professional support, feelings of incompetence, denial, and projection of responsibility, feeling total responsibility for assigned families, difficulties separating personal from professional responsibility, feelings of being a victim, ambivalent feelings towards clients, and about one's professional role and the need to be in control.

Some papers have dealt with the issue in terms of countertransference reactions (Jones, 1986; Krell & Atkin, 1984; Pollak & Levy, 1989). Pollak and Levy (1989) in their theoretical paper look at doctors' relationship to maltreatment in terms of countertransference. The concepts of transference and countertransference have been central to psychoanalytic thinking from the very beginning. Transference denotes the phenomenon that the patient attributes the therapist qualities that their early attachment figures have been perceived to have had. Countertransference denotes the phenomenon that the therapist on his part reacts emotionally to the patients' transference on the basis of their own history. Pollak and Levy (1989) use

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This article is the ninth in the series of invited commentaries celebrating the 20th year of *Child Abuse & Neglect*, and is published without editorial comment or input.

countertransference to denote the totality of the doctors' emotional reactions, conscious as well as unconscious, towards the child, the parents, and the abusive situation. The authors describe five different countertransference reactions, fear, guilt and shame, anger and sympathy. Countertransference reactions are not limited to doctors and the "50-minute" hour.

The limited attention this aspect of our work has received might easily be explained by the fact that it has to do with our own feelings and conflicts and that it is an area difficult to research, at least in quantifiable terms. Qualitatively it is there to be observed and documented and hopefully to be better handled in the years to come.

Hobbs (1992) sees the main hindrance to effective child protection work as being denial and different levels of recognition that one hesitates to take responsibility for. He also reminds us of T. S. Eliot's formulation "Human kind cannot stand very much reality." Henry Kempe, of course, saw denial as a phase in dealing with abuse. I believe that denial is not a phase, but a process that we continually have to deal with in ourselves and in society.

This short communication is based on four studies of workers (Killén, 1991, 1996; Killén Heap, 1981, 1988). "Worker" in this context denotes representatives from all professions involved with abuse and neglect. The aim of the studies has been to conceptualize the issue, in a way that could be useful for clinicians in their daily work.

The methods used in the first two studies have been in-depth interviews with workers. The focus of these studies was the abusive and neglectful families. To get valid data, however, I also had to focus on the workers. In the following two studies a multimethod approach was used. In addition to in-depth interviews with workers, observation of eight workers in case-discussions, analyses of the same workers case-records and decisions were used. It is also based on many years of clinical experience.

The conclusion of the follow-up study I carried out in the late 1970s, shocked me (Killén Heap, 1981). The study encompassed 86 workers. It showed with great clarity that it was more important for us to protect ourselves than to protect the children and the parents. The following study of 1988 showed the same tendency, but not as strongly. The two last ones have shown that seeing and not seeing abusive and neglectful processes is a continual struggle for the workers. The distress and pressures of working with neglectful and abusive families raise such problems that workers themselves need to defend themselves.

It is painful to face the anxiety, the emptiness, the grief, and the aggression that the child expresses in various ways. It is equally painful to understand and accept the parents' losses and their grief for the life that never materialized, the help to grow up that they never had when they needed it—and the experience of inadequacy, pain, and hopelessness they are left with.

To evaluate, to have an opinion, to take responsibility in ways that might have decisive consequences for both children and parents evokes anxiety and conflict in us. It would be remarkable if it were not so.

Further, we sometimes see that parents, despite great investments from the helping professions, do not manage to give the child a "good enough" care situation. To be part of a process where we from time to time have to remove a child from home also evokes strong feelings in us. The emotional challenge of facing these realities is tremendous.

We defend against facing both the realities of these families and what they do to us emotionally: our own aggression, grief, and anxiety. This is a problem for us, not only as clinicians, but also as researchers.

As professional persons we have both to function and to survive within this emotionally highly charged field. Not all of our ways of dealing with these situations are constructive and our need to defend ourselves will sometimes hinder good work.

We develop survival strategies, that is, we use some mechanisms that prevent us from seeing, mechanisms that make it possible not to see, and what is more the children are our "helpers" in this process.

Our ability to close our eyes to the suffering of children seems at times to be unlimited and I am not speaking first and foremost of society, but of us as professionals. How do we manage to do it? I will describe some of the mechanisms that most of us use in different degrees and how the children attempt to "help" us.

Over-identification is one of the most frequently used mechanisms that workers protect themselves with. The concept of over-identification is used and understood in different ways. I use it to denote a form of projective identification where we project onto the parents our own feelings and qualities or feelings and qualities we believe that we have towards children, instead of empathizing with and facing the parents' and children's realities.

We ignore or reduce the aspects of the parents' personality and life that place great burdens on the child. We attribute to the parents more resources for further development than they have.

This has some unfortunate consequences for the work with the families. The over-identification leads to treatment plans and aims which might not have any relationship either to the parents' potentials or to the children's needs. We often base our work on hope and belief in a development that there might not be basis for in the parents and their network. This is sometimes striking in relation to neglect.

We base ourselves on what is ideologically or politically in, instead of available knowledge. We tend to use only parts of the knowledge that is available.

Such over-identification leads to a tendency to minimize the abuse and neglect and what it costs the children in terms of daily suffering as well as the consequences. We develop a distorted picture of the children, we see them as healthier and stronger than they are and attribute to them qualities that we like to see in them. We interpret their behavior as positively as we can in a way that makes us feel better. Meanwhile the children use their resources mainly for survival and not for development and maturation.

The negative consequences of these mechanisms for the parents are more difficult to see. However, they are not to be underestimated. Over-identification with the parents results in expectations and demands on the parents that are higher than they are able to live up to. With too high expectations, we push them in the direction of some goals that would demand very different resources from those they do have. This of course leads to new disappointments and further reduction of the parents' self-esteem and functioning.

And further, over-identification prevents wholehearted acceptance of the parents. What we in fact are telling the parents is: I cannot stand seeing you the way you are. I have to close my eyes to your limitations. We create a more favorable version of the parents in order to be able to face them.

This makes it impossible to help the parents with those very aspects of life that they most need help with. We play into their denial of the problems that need to be solved to make the child's home situation good enough. This way we prevent progress and development. This over-identification process reflects lack of ability to face our own negative feelings towards the parents, our aggression, and the pain in the child as well as in the parents and ourselves.

Over-identification often makes it impossible to use professional authority when that is needed because we avoid seeing the need for it. It may, for instance, lead to postponement of placement of a child for many years, if that should be needed, until it is almost too late at least for a successful outcome for the child. Its developmental lags and emotional problems may have developed far and the attachment may for many years either have been very weak or very anxious.

As over-identification so strongly contributes to our continual investment producing no results it underlines our own lack of competence. This correlates highly with projections of shortcomings on each other and on the parents. Periods of over-identification are followed by periods of projection of low professional self-esteem, our aggression comes to the surface and scapegoats are easy to find in this difficult field. This again affects our cooperation with each other.

Closely related to this process is the mechanism of withdrawal from both the child and the parents, emotionally and even geographically. Home visits are postponed. We heave a sigh of relief when nobody opens the door, or the appointment is canceled. We collude with the parents in not facing the reality of abuse. We refer the parents on for further treatment even though we might be well aware of their very limited potentials for development.

Another much used survival strategy is that of using simplified treatment approaches where we reduce the complexity of the problem. Treating abusive families on the premises of a simplified model and not on the understanding of the dynamics and processes of abuse, helps us not to see. Sometimes it seems that the further the model is removed from the pain of the family and ourselves, the more popular it becomes.

Another mechanism that also has been observed to prevent us from seeing the reality is what I have called problem displacement. When the chaos and problems in the families are overwhelming the workers focus on one of the many aspects of neglect and abuse and not on the process of neglect and abuse itself; for instance, they focus on the developmental lags of the child, very important indeed. But trying to alleviate developmental lags does not stop neglect and abuse.

Lack of a common wide-enough theoretical frame of reference for observing, analyzing, assessing, and treating abusive and neglectful families also prevents us from seeing. This leaves the worker more vulnerable to introjecting the chaos, hopelessness, and anxiety that these children and parents signal. Instead of trying to observe, understand, and empathize with the family and develop some effective ways of working we will often introject the families chaos and burdens. This mechanism prevents appropriate activity and sometimes activity of any kind as well as preventing the workers from coping with his or her own feelings. The family's problem becomes the worker's problem and it becomes insolvable.

It leaves the workers feeling as hopeless or as anxious as the families do. It tends to paralyze them. Creativity disappears. That these reactions are contagious may be observed in case-conferences.

These and other mechanisms prevent us from seeing how detrimental neglect and abuse is to child development and how resistant to treatment serious neglect and abuse often are. Protecting ourselves with these and other mechanisms takes much of our energy and probably contributes to our burn-out.

We can observe exactly the same mechanisms in society presented through media. The boulevard newspapers depict it, the over-identification with the parents, the empty cot with the teddy bear, the grieving parents, and the scapegoating of the professionals.

There are parallel processes. The society does not see the workers, the parents, nor the children. The workers do not see the parents nor the child. The parents do not see the children. Distorted perceptions on these levels certainly cannot lead to rational behavior or rational treatment.

Our own survival strategies interact with the survival strategies of the children. This interaction sometimes leads to complete blindness on our part. The child works hard to try to figure out and adjust to the needs of the adults and to carry their responsibility.

Some children's ability to overcome anxiety and to tolerate frustrations is considerable. They try to live up to grown-ups' demands and expectations. They are often hypersensitive to the signals the grown-ups are giving about how the child ought to behave. They learn very early that what is expected of them is to look after the adults, and this is an expectation they live up to. They look after the professionals sometimes just as well as they look after the parents.

At the same time as abused and neglected children carry much responsibility, they are extremely loyal towards their parents. Children's ability to cover up for their parents is almost limitless. Children know what the adult world does not want to know or what the professionals cannot cope with. This way they also help us not to see.

It is necessary that we try harder to see and hear the child better. That will help us to perceive the parents and the children more realistically. But how can we move forward?

There is a need to recognize and establish some norms in our various organizations that say that it is human to feel, and professional to recognize and accept the feelings that the neglected and abused families touch off in us. We are good at sighing and projecting together, not so good at exposing and accepting our own and each others' real feelings of aggression, anxiety, hostility, and grief. If we do not deal with these feelings we will not improve as helpers.

Our difficulties in seeing is of course not only rooted in our feelings towards the parents and the child, but also in our own childhood, not so much in what we have experienced, but how we have dealt with it. That is our own home work. Working in this field, there is a need to associate to and come to terms with one's own childhood experiences. That also enhances our empathy.

Closely related to the emotional challenge is the challenge of developing a theoretical frame of reference that reflects the complexity of maltreatment and the inter-factional developmental and systemic quality of it. We will not be able to deal with the emotional challenge unless we deal with the theoretical one.

The challenges of developing a comprehensive theoretical frame of reference has been difficult, not least because of our attempt to prove the abuse rather than to understand it. Trying to prove special parental actions or incidents makes it very difficult to focus on the interaction and processes in the family. These we need to understand in order to be of help.

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