Dear Dr Higgins,

I wanted to take the opportunity provided by the Discountenance and Creativity Corner to discuss the role of schools in working with children who have a heritage of intergenerational trauma.

I work in a regionalised school system as a student management consultant. As such, I am required to travel from school to school, work with children who present behavioural challenges and assist their teachers to better manage these children in the classroom. Many of the children that I see are deeply and multiply traumatised. Their skewed social behaviours are expressions of poor modelling, distorted mirroring and most alarmingly, intergenerational wounds that remain completely unaddressed.

Frequently these children are acting out the agony of their parents experiences of abandonment, violence, self-harm as well as negative experiences from a censorious school system of two or three decades ago. To compound their burden of parenting, many of these adults live with difficult children, minimal social networks, limited coping skills, welfare payments, violence, shame and social condemnation.

The usual procedure for children with disturbed behaviours is to medicalise, pathologise, and refer to a segregated student management setting that adopts a strongly behavioural approach. Parents are only involved when the child accepts placement at the unit, whenever s/he is suspended and also for re-entry meetings where the child's conditional return to school is negotiated.

I believe the medicalising of a child who is experiencing behavioural difficulties has many drawbacks. The onus of responsibility is shifted from the adults to the child, who becomes the cause, rather than a symptom of social distress. A mandate to medicate the child is implicit in this process. The child becomes calm or, at least, chemically restrained. If the medication has the desired impact, there is a reduced likelihood that the child's social and familial history and environment will be unpacked, or that ongoing abuse or trauma will be identified. Psychiatric diagnosis signals that this child requires specialist input and can no longer be dealt with by the ordinary classroom teacher or by other ordinary people. The child then develops a self-concept that is not conducive to mental health.

When we place all of our focus upon the child, we are refusing to think systemically or to see the child as a member of a broader social or familial system. I have had children referred to me, who, while having massive specialist input, (six or more unrelated professionals visiting them at school alone) have no peers and no advocacy. While each of the specialists may be doing laudable work, their collective presence compounds the problem, frequently endorsing the child's worldview of themselves as a person who is unable to make friends, speak on their own behalf, act with confidence, spontaneity or creativity.

I am of the firm view that we need to stop pathologising our traumatised children. We must begin a process of healing and create a supportive community that shares the responsibility for the well being of our young people. As health providers, educators and community members, we need to begin to heighten our consciousness of the child as a part of a social system and explore ways in which we can make our school systems more inclusive and supportive environments for families, particularly those who are disenfranchised.

It seems to essential me that we meet with develop trust and work effectively with parents in an environment, which we ensure, is accepting. In many schools, this is being trialled by inviting parents into the classroom to assist with reading, invitations to attend special cultural, sporting and prize giving days, hosting Dads and Granddads days, and so on. All of these actions offer the opportunity for parents and children to heighten their sense of belonging to the school community and to develop stronger relationships within the local school setting.

A positive connection with the child's family may encourage some vulnerable members of the extended school community to attend parent groups. While teachers and advisory staff are honing their skills in more effective behaviour management, the primary issue of repeated intergenerational trauma usually remains in the too hard basket. I am in favour of promoting classroom management with teachers and then switching the focus from the child to the adults in his/her family. Often considerable groundwork needs to be done before parents will even consider meeting with school personnel or attending parent groups.

I have facilitated therapeutic parent groups in a number of settings including a segregated therapeutic unit; a community based organisation and a government-

funded group open to anyone who identified themselves as stressed. In the first two, I worked with the participant's children and the staff separately. In the third, I worked only with the parents. The focus of all groups was to empower parents, to build connections and to explore intergenerational trauma. Techniques were not the focus of these groups.

In all the parents groups, significant shifts have taken place without the need to work with the child's labelled dysfunctionality. For example, in one group a father was painfully disconnected from his 14-year-old daughter with a suicidal ideation. During groupwork, he made the realisation that he was 14 when his mother suicided and that he had been disconnected from himself since his mother's death. He could not bear to have any relationship with his daughter, whose suicidality put him in touch with his own unresolved grief. Work with this man, whose issue was central to the group, brought about a significant shift in his daughter's willingness to embrace life. His work had the additional advantage that when he visited the unit, we were able to speak more broadly and openly of the progress of that the family had made and to draw upon his expertise to chart future directions in his family.

In another group, I realised on the first night that all the parents present were able to display huge degrees of competencies when their children were behaving either in a tyrannical manner or being vulnerable and waif-like. However, when their children were calm, which may have been only be for 10 minutes at a time, the parents were at their most tense and had no skills to handle their child's calmness. They tended to wring their hands and precipitate or await the storm that they were so well equipped to manage.

When I presented this information to the parents, using action methods, they were shocked. We explored this issue in the group. Parents were asked questions such as, "How would your relationship with your child change if you were able to experience calm during their quiet periods? " The members of the parents group were quickly able to recognise a dynamic of which they had previously been unaware. With a large degree of daring, openness and determination, they altered their own behaviour and enjoyed these new, healthier developments in their child's ability to relate and to focus. Their child's progress was a natural and welcome response to a more favourable social environment.

The shifts that occurred as a result of this work were more expedient and lasting than the relatively laborious task of working with a child in isolation. A child does not structure the social environment in which s/he dwells, nor generally do they see much value in increasing their levels of calm in chaotic circumstances!

Yours sincerely

Keren Griffin

Student Management Consultant>

My response

<Dear Kerin,

Thank you for drawing our attention to this profoundly important issue!

Back in the early nineties, I worked as part of a small national team of mental health professionals employed by the Commonwealth Attorney General's Department. We had numerous responsibilities. They included the provision of recommendations for funding and the clinically monitoring of innovative "family skills" programs. These programs were designed to prevent further perpetuation of intergenerational abuse and trauma.

There were creative and highly effective programs developed by dedicated workers and agencies in every state and territory of Australia. These programs targeted the most disadvantaged among our population and the focus was on teaching traumatised parents to parent themselves in compassionate, consistent and firm ways. They were then able to use this newly internalised wisdom in nurturing their own children.

I could not agree with you more!

Kindest regards

Jeannie Higgins>