

# Reply to Anne Welfare

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We welcome Anne Welfare's response to our paper and wholeheartedly endorse much of what she asserts. We are especially indebted to her for clearly portraying the genuine difficulty experienced by adherents to the dominant discourse (that denial must be confronted and worked through) in considering alternative responses to denial.

We endorse completely the value to victims and survivors of their abusers taking responsibility and understanding their own cognitive distortions, their tendencies to denial and minimisation, and their cycles of offending. Unfortunately, regarding this as an essential prerequisite for therapeutic work with intrafamilial abuse has led, in the UK, to cases being regarded as untreatable, where denial is maintained. Resolutions was developed to permit a therapeutic response to the most serious of these cases.

In the UK, only a small minority of alleged offenders ever accept even partial responsibility for abuse of children. In such cases many young people who have disclosed abuse either remain in care (often subsequently retracting the allegation in order to return home) or remain at home, and, when the alleged abuser subsequently returns, the Courts do not deem it in the child's best interests to remove them. In such circumstances the UK Children's Act (1989) requires that primacy be given to the wishes and feelings of the child, thereby creating the therapeutic dilemma of how to enable the child to remain with such a family in safety from future abuse.

The dominant discourse assumes individual change on the part of the abuser to be an essential prerequisite for successful therapeutic work; Resolutions does not share this assumption. The difficulty this poses conventional therapeutic approaches is exemplified by Anne Welfare's suggested restriction of these ideas to those cases of medium to low risk where no disclosure has occurred. In fact, Resolutions was developed for (and continues to treat) only the most serious, high risk, denied cases of physical and sexual abuse (including child deaths and cases of factitious illness spectrum).

Our research findings which revealed re-abuse rates of 7%, compare favorably with the range of 25–40% associated with conventional approaches to such cases. Thus Anne Welfare's suggested restriction would remove this approach from precisely those cases where it has proved its value. Our research findings refer to the Resolutions work as a whole: as mentioned in our article, the 'similar

but different' has never been considered as a 'stand alone' technique.

A second consequence of the dominant discourse is the tendency for therapeutic approaches to be evaluated exclusively in terms of their probable impact on the alleged abuser. To quote Anne Welfare, '... offenders need to understand their cycles of abuse and their cognition around the abuse. Without these additional factors, I believe that they are still at risk of re-offending.'

UK evidence suggests a more pessimistic reading, that the risk of re-offending is often undiminished by the kind of intensive individual therapy which Anne Welfare advocates. It seems often that only external constraints restrain abusers from re-offending. The 'similar but different' approach offers a way of focusing on these same concerns when they are denied. It is not intended to help alleged abusers gain understanding; its value is systemic, in making available to non-abusing carers the information, ideas and resultant issues known to Child Protection professionals but often not to the general public.

Ours is a systemic rather than postmodern approach, seeking to ensure future safety through changes in the social system around the alleged abuser, creating external constraints via the enhanced vigilance of the non-abusing carer, extended kinship, and other social systems. Accordingly we are in complete agreement with Anne Welfare as regards the clinical importance of the non-abusing carer relationship. Non-abusing carers have usually been distanced from their child by the grooming process and the re-establishment of these relationships is central for future safety.

Another component of Resolutions, the Family Safety Policy, directly addresses the myriad practical arrangements necessary to ensure future safety by attempting to preclude the possibility of any future allegation. This work is not conducted in the role play, and the alleged abuser is routinely excluded from these discussions, (which often extend to a quarter of the total time spent in therapy). They return only to 'sign up' to the safety policy when it has been finalised, customarily witnessed by the assembled non-abusing adults and all children of the extended kinship system. Additionally our work always includes individual sessions for adults and children where requested and, or necessary.

We are grateful to Anne Welfare, her response having helped us to clarify some fundamental aspects of our work which may not be clearly expressed in our paper.