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Cases in the field of paediatric social work - when parents and paediatrician diverge from the child's best interests.

My whole professional career has been devoted to the protection of mothers and children, for 10 years as community doctor and then, for 20 years as head of department in Paris.

This service providing health promotion was inaugurated by the National Council of the Resistance and created as soon as the second world war ended at the same time as the social security system. It formed the foundations of a preventive medicine programme dedicated to pregnant women and children under six years of age, to undergird the demographic reconstruction of the country. It is a service of public health which applies without exception to the whole of the population.

With the passage of time, its mission became richer and broader and PMI (Protection Maternelle et Infantile) or maternal and child welfare services progressively evolved from a form of medicine practised in the style of Pasteur towards a service of social health, in charge of family planning, child protection and the promotion of family and child health. It integrated into its practices all the new research into child development and family dynamics done in the 20th century. In particular, starting with the concept of vulnerability, it was able to go beyond its initial ideology of social hygiene centred on the control of the labouring classes which was in vogue at the beginning of the twentieth century. It made itself available to all the social classes and suggests ways of support based on the families' potential.

In order to do this, it massively diversified the skill sets of its professionals, paediatricians, gynaecologists, paediatric nurses, psychologists, midwives, physiotherapists, dieticians. It developed partnerships and resources in multiple different institutions with creches, services specialising in handicap, hospitals, psychiatric services, social services, administration and judicial services for child protection, the associated teams dedicated to very diverse populations, in particular those which were vulnerable and/or migrant. It finally managed to integrate the subtleties and the difficulties of team-work in complex situations. It meets with families in centres for medico social clinics but can equally visit them at home.

Little by little, it came to be perceived by the families as a service to call upon, free, well-meaning and helpful, allowing them to tackle all sorts of problems of physical health and of relational or social difficulties, while facilitating access to other services, health or social, relevant to these problems. Even though they are accessible to everyone, these centres of child health are essentially used by families of modest means, some even very poor, many are the result of immigration, coming from all over the world, with a significant proportion from West Africa. In Paris, about 50,000 children, from birth to 6 years old, benefit from consultations preventing and diagnosing disease and promoting health.

In most cases, alliances between families and the teams at PMI form easily. A shared understanding of the problems means that they accept the recommendations of the professionals even if in order to do so, they require a certain level of buy in and reciprocal adjustment.

Having said that, this isn't always the case. Some situations lead the parents to confront the professionals of the PMI or their partners, for varying reasons which are always legitimate when viewed from where they are coming from. Compromises therefore need to be sought and ways found for them to evolve in their opinions. As the doctor responsible for this field, these complex situations always land on my desk, either directly or as I supervise the professionals in my team.

The conflicts are intimately related to questions concerning the best interests of the child. What are acceptable ways of looking after a young child? What is the threshold beyond which their needs are not satisfied? Beyond what point are they in danger, whether physically or developmentally? The causes of disagreement about these questions comes back to the different points of view whether cultural, social, educational or psycho-affective. The professionals share the convictions and the reference points which are popular in France. A certain number of them are inscribed in the laws of child protection and the professionals are obliged to uphold their validity faced with parents who refuse or are prevented from adhering to them. As a public service, they are invested with an authority which can allow them to mobilise the administrative and judicial authorities, even the police, to uphold these reference values.

In other words, such situations are hugely asymmetrical. It is essential to embark on them bearing in mind all the respect due to the parents' convictions and establish with them a dialogue which allows them to experience this conflict of values without feeling humiliated or disqualified as parents, and to understand, if not accept the consequences at the moment the final decision is taken.

I will illustrate these situations of conflict using three examples of problems taken from those in which I have been particularly involved; infantile lead poisoning, female circumcision or female genital mutilation (FGM) and child protection.

But first, I would like to describe an anecdote which bears witness to the fact that different perceptions of situations are not always synonymous with conflict, and they can even be turned into a cause for humour.

While seeing a mother from West Africa with her young child, I notice that she seems pregnant and I tell her my impression. Immediately, her face clouds over and the conversation which was cordial up until then dries up. The consultation ends rather coldly. I don't see this lady before my return from holiday and, in August, as I am crossing the town square, I notice her coming towards me. She doesn't avoid me, and on the contrary, she approaches me smiling warmly and as she is going past shows me the baby attached to her back and turns around with a radiant smile tinged with gentle mockery, as though she's played me a good trick. I then remembered that it is not done to talk directly about their pregnancy with certain African women, because it might attract attention and perhaps bad luck for the baby which is still hidden. My bad. But it all ended well, and the lady didn't hold it against me.

Moving on to infantile lead poisoning, this was an exceptional adventure. Firstly, l need to give you a brief outline. In 1985, a young African child dies in a paediatric hospital in Paris of encephalitis secondary to lead-poisoning. Some toxicologists and hospital paediatricians get together and contact me because some children in my service have been diagnosed with lead poisoning. This is a pathology which I know very little about, but very quickly, my toxicologist colleagues and I understand that we are facing a public health problem akin to the 'silent epidemic' in the United States. We rapidly become convinced of what is happening based on well-documented evidence; the children are being poisoned in their homes by absorbing flakes or dust from old paint, rich in white lead, containing elevated quantities of lead salts which are soluble in gastric acid and therefore absorbable by the gastro-intestinal tract. The poor state of repair of the old paint accentuated by

overpopulation of the buildings and by the humidity, made them very accessible to children who scratch them to get the paint flakes or who transfer them from hand to mouth via the dust. Clearly, all our little patients, living in clearly and dangerously insalubrious conditions, are exposed to this poisoning. And this is going to involve a lot of people.

We therefore undertake a large scale and systematic investigation of this hidden pathology. The discovery of the first few cases was fortuitous. We need to take a proactive stance. The poisoning is in fact most often asymptomatic. The deleterious effects on neurocognitive development only become evident in the longer term. At the time the threshold for treatment of lead poisoning was a lead level of 250µg/l. Treatment consisted of a five-day course of intravenous chelation at the day hospital. We will rapidly realise that we are faced with children who have been poisoned over a long period of time, who have accumulated reserves of lead in their bones, which release lead into the circulation after chelation leading to relapses. The pathology is truly chronic, necessitating repeated courses of chelation for each poisoned child, and for those who are not yet poisoned, but remain exposed to the risk factors in their housing, regular investigation aimed at prevention.

Of course, parallel to this campaign involving a wide-ranging investigation, we institute measures to combat the risk factors, disseminate advice about domestic health, and confirm the reality of this risk by measuring the levels of lead in the paint. It would still take years before the politics of public health and housing put in place measures to reduce or palliate the risks and eradicate the sources of lead and rehouse the families. Together with the associations of health for migrants and Medicine without borders, we tried to search for solutions whereby we could remove the paint which was causing this. It was thus that we received one day a visit from a Belgian industrialist who proposed a scouring process for the walls using caustic soda which would turn out to be ineffective. He asked to visit one of the lodgings and a family had agreed to let us visit them. On emerging into the street after this visit, this grand and imposing gentleman insists on a double whisky before moving on to anything else. This wasn't that easy to find at 10 o'clock in the morning in Belleville, and once restored by his drink, he declares himself overwhelmed by what he has seen of the shamefully unhealthy conditions of this family lodging.

While waiting for a solution, we explain to the parents that we need to take blood from their children who seem healthy as usual. More often than not, given the results, they must have several sessions of treatment at the hospital. We would not have access to oral chelators until several years later. We also explain all the precautions they need to take at home to protect the children from the paint, but we are still returning them to the place which poisoned them after their treatment. Lead poisoning is well and truly a pathology found in the poor child, in poor lodgings and what is more, in Paris, in an immigrant population.

This came as a terrible shock to these families, the individual ones affected and for the whole community of families originating in West Africa who were the most affected because they had the worst housing. In spite of the significant disturbance to the organization of their daily life caused by the treatments, in families where several children were sometimes affected simultaneously, most of the families applied themselves to the therapeutic advice, which was often rigorous since the lead levels could attain impressive levels, pretty often above 1000 µg/l. Some however had trouble conceding the need for such treatment, and it was sometimes necessary to apply the threat of the law.

So, we were basically occupied in applying our protocol of detection and follow up, with messages which were well established, and whose success allowed reduction below the toxic levels. Our analysis of the problem as well as our proposed solutions both elaborated and suggested to the families were based on the *biomedical paradigm of poisoning*: a poison gets into the individual, its source is identified, we try to bring it under control, and the poison is removed from the individual by another poison. In effect, acting as an ambivalent *pharmakon,* EDTA, the healing chelator, very quickly showed itself to be

nephrotoxic once used above certain threshold doses. It is clear that for the families, understanding and accepting all this was really difficult.

It was in collaboration with our anthropological colleagues from CNRS (National Centre for Scientific Research), specialists in West Africa and in the Soninke (a West African ethnic group), that we understood that the explanatory paradigm which suited the affected families best was that of '*misfortune'*. It resonates with the complex ties linking individuals to their familial and tribal community, in France and back home. It makes use of the links to ancestors, to spirits, to everything which makes sense when it comes to understanding the world and the disturbances which can suddenly intrude. The families observed the prescriptions of white biomedicine, partly because despite everything they trusted them, and partly because their choice was constrained by a public authority. But, in parallel, they had an important recourse to the healing figures in their traditional universe, the witch doctors, the healers. They also had faith in the ethnomedical service of the Georges Devereux hospital, in the Avicenne of Bobigny hospital, directed by the ethnopsychiatrist Tobie Nathan, which put in place services adapted to this new problem.

We warmly welcomed this double allegiance. Since our own care programme was not threatened, we were able to welcome into our PMI centres sessions of traditional care. I actually took part in one of them. Of course, the meaning totally escaped me, even when, sat in the circle of various carers and families, I saw an egg appear which had to be handed from person to person. The important thing at that moment was to bear witness to the belief in the therapeutic effectiveness of this treatment, just as the families acknowledged that of our biomedicine.

It was thus that we were able to resolve the complexity of affiliations and faiths, in this encounter between cultures, which was able to happen without trauma, each respecting the other.

In the fight against female genital mutilation (FGM) of young African girls, things went rather differently. This traditional practice which is mainly found spread through the African continent was the object of study which evolved with the passage of time. At the start of my professional practice, in the 80's, there were contrasting reactions to it. While some denounced it as an intolerable criminal assault on the integrity of the child, many argued that we should respect it in the name of respecting cultural traditions, which were intolerant of our criticism which was then viewed as a mark of neo-colonialism. The discovery of circumcision in a young girl brought for a paediatric consultation did not unleash formal proceedings, just sometimes a comment with no consequences. Reporting it to the judicial authorities was left to the individual practitioner's discretion. The effects were uncertain. Clearly, it was a problem that no-one knew how to deal with.

In the 90's, several legal proceedings reported in the press implicating African practitioners of female circumcision who had come to practise in France, and the families who had requested their services, allowed us to reflect and to move towards more reasoned positions. We encountered associations fighting for the rights of women against sexual mutilation, French (GAMS, Groupe pour l'Abolition des Mutilations Sexuelles, des Mariages Forcés & autres pratiques traditionnelles néfastes à la santé des femmes & des enfants – A charity campaigning to abolish FGM) but also African. We learned that many African countries had drawn up legislation forbidding these practices and imposing penalties. We discussed this with mothers and fathers who were trying to find a way of escaping their community's injunctions and protect their little girls.

We therefore decided to consider FGM as a crime and to treat it as such. We therefore engaged in a concerted group action with these families and associations, as well as with the service for the protection of children and justice for minors, to define a coordinated intervention. We launched a publicity campaign to inform and prevent it with all the families using our service. And I drew up a memorandum making it obligatory to report to the public prosecutor any cases of FGM with a view to launching a legal investigation. This report to the prosecutor was then systematically followed by interview with the parents, with the possibility of taking the child into care. The investigations focussed on finding the practitioners in France, the involvement of the parents, whose defence was usually that it

had been the intervention of older women while they were visiting their home country, in their absence. What is more, for girls not yet circumcised, a process to protect them during visits back home often asked for by the parents, was organized by linking with the associations who could mobilise their local members during their stay at home. Finally, in particularly difficult cases, the judge could prohibit the child from leaving the country.

We did for a while fear that the violence of these processes would put families off from using our services and that they would no longer bring their children to see us. But this didn't happen. We continued to see young circumcised girls, usually on their first visit, but sometimes after a visit back home. It grew less and less common.

In fact, even if, in the beginning, some of the families supported such a programme and even asked for it, they were a tiny minority, and most didn't question this practice, at least not explicitly. Just talking about preventing it did not relieve the pressure of community and tradition to do it. And the active participation of certain families in this fight made evident the divergent points of view even within the African community. Nonetheless, once the programme had been put in place, things progressively evolved. It became easier to raise the question, to state that in French law assaulting the integrity of the body was forbidden. Bearing witness in the public forum, confirming it by significant actions allowed numerous families, the mothers in particular, to work out what they thought in regard to this practice, to dare to take a stand where they refused the mutilation of their daughters, a mutilation which they themselves had undergone, for it was quite something to risk being taken into custody, to risk criminal sanctions if one was an honest family man. Families choosing to refuse the practice could thereafter rely on protective processes put in place by the judicial authorities. The rigor of these processes helped them to justify their position and to dissuade those in their community who were bringing pressure to bear, including when they went back to their home country on holiday. So, we observed little by little the almost total disappearance of circumcision of very young girls who we were following up to the age of six.

Nonetheless, one mustn't think that the practice of FGM has been eradicated. Very small children have been well protected. Families who had just arrived were rapidly informed by the community bush telegraph of the measures in place. But, for all that, the all-pervasiveness of the tradition is not going to disappear so quickly. We have observed the arrival of a strategy displacing the practice of FGM to ages where the medico-social supervision is less. School health services have found themselves on the front line when detecting girls who have had FGM during a holiday. This issue, like that of forced marriage, has now become one of their main preoccupations.

For my part, having seen this slippage in ways that girls are exposed to the risk of FGM, I undertook a new consultation with professionals and with associations, and drew up a new memorandum. This focussed efforts at the level of centres of family planning, for the adolescents asking for contraception and in due course for protection, and for pregnant women for whom it seemed essential to develop more education and to support them in protecting the girls yet to be born.

I have learned from this experience that it is important to define clearly the principle which one wishes to promulgate, to not give up on putting it into practice because of weakness or complacency, even if families are hostile to it. Those families are very capable of taking a stand in opposition to professionals looking after them while at the same time continuing to ask them for help. Either professionals draw on arguments and proofs to make the families change their positions, or they bypass them if they don't wish to change. In all cases, it remains axiomatic that one's convictions are not betrayed in the dialogue between professionals and families.

When it comes to child protection, things are equally very complex. There is a code of reference more or less universally adhered to, of things it is forbidden to do to children, also people who are vulnerable, ill, handicapped, elderly. It is inscribed in law and makes it imperative that any acts, abuse or neglect are reported to the judicial authorities without the need to adhere to the usual rules about patient or client confidentiality. Such situations are then evaluated by multidisciplinary teams from different institutions. The

different professionals involved together with the families can have widely differing opinions as to the process, who is responsible or why it happened, even when the facts of the ill-treatment are undisputed.

In practice, first line paediatric services such as that at PMI, are mostly confronted with cases of ill-treatment which I will define, where the work with families is on the one hand essential for evaluation of the situation, but also to ensure a favourable outcome for the child and their family.

At the beginning of the 1980's, we had at our disposal well-established facts about the psycho-development of the child, parental competencies, family dynamics and the pathologies of intrafamily relationships. There had also been a critical appraisal of the policy of placing children in care and there was a recognition of the devastating effect of separation and family break-up without special provision being made. Finally, people were ready to admit that families who were poor or with severe social problems did not have the monopoly on abuse. The concept of vulnerability led to children in difficulty being offered help within their family circle including families who had up until then been unreachable by the social services. All of this forced an evolution of the principles and types of intervention delivered by services and teams working with failing families and those who were really struggling as parents. It was no longer a question of separating children from a toxic family environment, since the placements resorted to up until then were just as toxic. The time had come to work with the families by keeping the child in their home for as long as possible, by developing alliances and psycho-educational means of helping them, allowing the best possible support for parenting skills.

Situations involving child protection are psychologically and emotionally complex. The ambivalence of the love-hate emotions between parents and children is basic to their relationship, with a continuum between harmonious relationships and those dominated by violence, neglect or rejection. The work of professionals, such as Myriam David, have greatly helped teams to understand what was going on, over and beyond how things appeared and what was said, in the pathological familial ties and interactions disturbing family relationships and equally, in the interactions between families and the professionals who were trying to help them. In effect, the mothers (for it is most often the mothers who one encounters) would cling to medical or social professionals, many of them trying to validate the different contradictory feelings which they were experiencing at the same time. Such a mother is incapable of satisfying the basic needs of her child, such as basic hygiene, an ordered life, a coherent educational and emotional presence. She appears to be gravely negligent, even sometimes verbally and physically violent. She lets her children place themselves in danger, and is, in short, a 'bad mother'. She also asserts loudly and strongly her attachment and affection for the child, sometimes expressed in an extravagant fashion, in a way which shows her despair at not being 'good enough' and her terror at the threat of her children being taken away and placed in care. The misfortunes of her own life can end up repeating themselves in her, without her seeing clearly what the stakes are. These two faces of Janus are sincerely meant and each needs to be taken into account. She will show and confide different pieces of her interior puzzle to the professionals around her. By the process of projection which will be set in motion once a serious and effective relationship is formed, one professional will be the recipient of hate or of violence and the other of the loving and devoted mother. When the intervention has the explicit aim of maximising competencies both actual and potential, it is absolutely essential that the different professionals work closely together.

For example, a mother of two children lacks energy, she is a bit overwhelmed, her family equilibrium is precarious with a husband who probably has a double life. She relies a lot on the professional team to take her decisions for her. She is so isolated that, when her third child is born, she has no-one to look after her two older children and they are placed temporarily in care. I am worried by this and I go personally to see her in the delivery ward, something which I never do, but I want to assure myself that she really wants her children back once she goes home. I am right to be concerned since children's services is against her having the children back on the basis that the mother seems incapable when they meet her. I will obstinately fight for six months to reverse this

decision which I have always judged to lack foundation and to obtain the return of the children to their mother.

Multidisciplinary working therefore needs meticulous coordination to hold together these extremes and allow them to work. In the end we can measure the success, or the effectiveness of the various interventions undertaken together for the benefit of the child. The parents end up adhering to the implementation of an educational process, the taking in hand of a handicap by a specialist team, putting the child into a creche or day nursery, the wearing of glasses which had been prescribed long ago.

The contact with complex psychological processes can uncover emotions linked to the individual history of each professional involved, which can unleash defence mechanisms or rejection, or the opposite, too deep an empathy. It is therefore essential to put into words these conflicts in order to protect oneself, protect the families from acting on impulse, and particularly from involving the law or asking the child to be placed in care.

For a young isolated mother, putting in place education and administrative help allowed us to appreciate the complexity of her ambivalence of her attachment towards her young boy. He is about a year old. The teams are divided, some request that he be taken into care, and others hope to support the family and keep him at home a bit longer. We arrive at a compromise where we decide not to remove the child. The following day, the young woman appears in my clinic, makes a scene, forces her way into my clinic room and throws the child onto the changing table while shouting in exasperation. She is forcing our hand, overwhelmed. She is also protecting herself by coming to us before she abandons her child, sure that we will take over from her. And that is what happens. I call the AEMO service (Assistance Educative en Milieu Ouvert - A service in charge of children who live in their own family with the support of social workers) who come to collect the mother and child and organize a placement.

If taking the children into care is never an a priori solution, it is always there in the minds of the professionals as a possible final solution. Parents who have often been in care themselves or see it as a threat because of the long social memory of the poor, dread it from the start and often try to fend it off with strategies which are often pathetic.

In this family, psychiatric illness reigns, but there is also a genuine attachment to the two children. The mild mental fragility of the mother means that she is not good at the basic care of her children. Their hygiene is appalling, and the family is accompanied by the odour reminiscent of a sewer. As for the father, he is permanently in a paranoid delirium and moves around holding a lit lighter which is supposed to chase away evil spirits. When he brings the children to clinic, he passes his lighter around me and around all the objects on the table and holds his head very close to mine above the children as I am examining each of them. When one was admitted to hospital, he exorcised the intravenous lines, which the nurses found very difficult. These children were definitely showing signs of distress and I felt it best to remove them from the family situation. No effort at education had had any success and the family was hostile to psychiatric services. But their attachment to each other was so strong that I was ruled against. I therefore went to see the children's judge to try and convince him. He was a young man in his first post, talked to me of the father who didn't seem so bad to him, while mentioning particularly the need to open his window to air his room each time they met. He was amazed when I described to him what went on in our consultations. How could I be supportive of such behaviour? Well, judge, that is my job. Finally, a young persons' team ended up retrieving the children one day when their father had a paranoid crisis at home.

As for families who are not used to the medico-social services, intervention by them can be perceived as an unbearable stigma, which they need to get over before they can accept the help that is offered.

Multidisciplinary meetings between professionals from different professions and institutions are therefore essential to maintain coherent support for the family where each person is aware of the role the family see them as playing, and the aims are shared by the different participants. These gatherings serve as places of synthesis, where the

disagreements sometimes play out in mirror image to the psychological fights happening within the families. They also guard against progression towards violent acts.

For my part, in addition to these meetings, I had instituted work sessions with the paediatric psychiatric team exclusively for my local team of nursery nurses. These professionals, all of them women, were particularly exposed to families projecting on to them, and to difficult interactions with clients for they were visiting families' home on their own. Once a month, we revisited situations, insisting on hearing how it seemed to them and how they felt during and after the visits. Initially reticent, they started to talk about ancient stories which were well in the past and resolved. Little by little, the situations they described started becoming more recent, then those they were actually in the middle of and finally they could talk about a case as soon as they took it on, in order to prepare themselves for an intervention which they guessed was going to be difficult. To put into words the emotions at play, is to both help them to be even-handed in the position they take up and to protect the family from unfortunate reactions which might stop them from listening without prejudice. These exchanges were a good way of preventing any exercise of power inherent in this sort of intervention. For the families, their capacity to disagree was safeguarded which in turn allowed a true evolution towards a positive outcome.

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How to read, with the eye of faith, these three examples which are so different; lead poisoning, FGM or female genital mutilation, child abuse, together with the way I approach them with my teams?

I propose three ways of reading this, at different levels, which I will leave you to form your own opinion on.

The first, I will name: **How does this relate to the law?**

These stories talk about the confrontation between what is viewed as normal, here medical or medico-social, backed by all the weight of the law, and the liberty of the patients, here the parents responsible for the care of their children. They can accept it totally or partially, but they can also refuse it, oppose it using strategies of avoidance or escape.

These situations replay the eternal split between the spirit and the letter of the law. *The Sabbath is made for man and not man for the Sabbath,* said Jesus when healing the blind man, at the wrong time, in the wrong place as far as the authorities were concerned, but at the best and right time for the blind man who was healed.

There are ways and ways of observing the Sabbath. According to the letter of the law, by observing the rituals and ignoring the man who is suffering and asking for help, or in spirit, by honouring the Saviour by caring for his creation, according to his commandments. The Sabbath is not nullified by something which seems to break a rule. On the contrary, it is respected by a sublime reverence for higher law, that of the Holy Spirit, rather than by being dragged down by pointless rituals. Antigone isn't saying anything different when she opposes the law of man and the law of the gods, which takes precedence. Christ tells the teachers of the law who are condemning the woman caught in adultery to examine their consciences; who are you to judge? We are dealing with a powerful anthropological paradigm, the spirit of conscience and of the heart is stronger than the law of stone.

The practice of paediatric sociology is permanently backed by the law, which in the end is in the background in all professional choices. It creates a framework of standard behaviour which is socially acceptable or reprehensible. It can he used in encounters with families as a weapon of power, even all-powerful, but it can also serve as a springboard to open a

path to a life liberated from those factors which weigh people down and constantly return them to the same narrow and downtrodden existence. This path taken with families always involves a degree of risk, counterbalanced by confidence in their abilities to overcome their predisposing risk factors. The law becomes a walking aid.

The second key to reading about this, is **the look.**

These families are like the rich young man who approaches Jesus to ask him the path to the Kingdom. Jesus sees him arrive, with his fine clothes, his upright posture and his importance. He sees in him the marks of all that which will hold him back as he sets off on his journey. And yet, in Mark 10v21, 'Jesus looked at him and loved him.' He loved him when the young man could not make up his mind to shed all impediments to follow him and he did not judge him but simply talked of the difficulty of his chosen path. With the families who approach professionals to try and rise above the weight of all the social and psychological determining factors which keep them in their unhappy situation, a look of love and confidence in them is needed at the same time as one is suggesting the difficult path they are going to have to tread. We need to recognise the human capacity to break free of negative factors, even if it is well hidden, to help to emerge and render effective the competencies which necessarily exist in every human being. It is because they encounter a look which is always friendly and confident that families return again and again despite failures and difficulties. And when one asks oneself, 'Who can be saved?', our faith hears Christ: 'For man it is impossible, but not for God, for all is possible for God.'

And finally, the third key is **the Word.**

In the most terrible situations of oppression or of violence, it is the word which allows us to name the humanity which is still and always present in the most appalling of men and women. By making oneself open to the meaning of what is at stake, it allows us to no longer be at the mercy of our demons, and to escape from the lethal weight of wrong-doing. It frees up possible escape routes towards life itself. In the image of the Word of God, Jesus Christ, the 'Word incarnate' who opens up a way of life where God comes to meet with mankind.

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