CHILD COUNSELLING INTERVENTIONS TRAILED IN THE FAMILY COURT OF AUSTRALIA, WITH FAMILIES WHERE VIOLENCE IS AN ISSUE.

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Introduction

This paper discusses clinical interventions trialled on an informal basis in the author's day to day practice, resulting from her observations of the need for specific counselling interventions for families presenting to the Family Court (Australia), where violence is a problem. The experience of children as witnesses or victims of violence is increasingly being recognised and understood in the context of their traumatic experience and the resultant impact on their development, coping, and future functioning as adults. The documented overlap between domestic violence and child abuse (physical and sexual) demands a child protection approach in these cases and refocusses the responsibility of the legal systems to appropriately respond to these children's experience. The paper discusses treatment interventions trailed with families where parents have made contact/residence applications to the Family Court and who are mandated to attend counselling.

Management of Family Violence Cases in the Family Court

The role of Family Court counsellors is to facilitate resolution of issues in dispute (conciliate) between parents. Court counsellors also have an assessment role and make case management recommendations to the Court. The progress of a case through the Court, if proceeding to trial, may take up to two or more years. The counselling intervention is confidential or privileged. Counsellors when ordered by the Court also prepare family reports or evaluations, which become part of the evidence at Interim Hearing or at Trial.

If parents are unable to resolve their dispute about their children, using the (confidential) conciliation options mandated by the Court, it rests with the Court to make interim decisions about contact and residence at the first Hearing. In cases where family violence is an issue, the Court generally has little information apart from the adversarially framed material, usually conflictual and contradictory, presented by each parent, via their legal representatives. There are few options for assessment and at the first hearing no time is allowed for in depth canvassing of the issues. The options for the Court are somewhat constrained to the simplistic and rigid outcomes of ordering contact (sometimes supervised), or in rare circumstances, no contact.

These problems of lack of time and inadequate opportunity for assessment at first Hearing, has led me to trial a range of counselling interventions involving both parents and children. The interventions trailed have been "confidential" or "privileged" (ie. not reportable to the Court) and have been undertaken following an agreement negotiated between both parents and in conference with their legal advisers. There are limitations to this confidential, consensual process when dealing with violent perpetrators. On occasion, the perpetrator will agree to comply to avoid the matter being closely scrutinised by the Court or as an attempt to maintain some control or link with the estranged partner. In consequence, the confidential status of the intervention is problematic. Without a capacity to report to the Court the process is open to manipulation for the above reasons.

The Need For Case Specific Response

Domestic violence can derive from multiple sources and follow different patterns in different families. These cases require differential clinical diagnosis and case specific responses in decisions about children. Criteria for identifying potential for counselling, which could influence Court response, fall into two broad categories:

(1) The violence is pervasive and severe: the woman is too confused and/or frightened to assert her position in her partner's presence, or is traumatised and numbed to elements of risk for her and her children, and where the man indicates no ownership of his problem, exhibits little or no desire to change and in consequence is likely to increase his coercive manoeuvres if he senses any changes in his wife. The worst of these cases would suggest no contact with the perpetrating parent. Options for management in this category could include no contact until further assessed, or limited supervised contact while being assessed.

(2) Potential for reconstruction of family interaction is evidenced if the woman still has some capacity to independent function within the relationship and outside of it, and the man shows some readiness and capacity to take genuine responsibility for being violent. Options for management include a range of contact options monitored over a set period, while assessing potential for reconnection. It is this category that has been targeted in the interventions trailed.

The Model:

The model trialled involves working with both parents and the child/ren on an individual basis and jointly at various intervals. The general goals of this work with each family member is to name the violence, assign responsibility, to work through the traumatic experience, and to allow time for personal integration and re-stabilisation. Reconstruction and setting expectations of new standards of behaviour are prerequisites to introducing or increasing contact. The process generally starts with an agreement to trial minimal contact, which can be increased at the pace that is appropriate to individual family members. Monitoring and review occurs over 3 - 12 months.

The Role Of Therapeutic Intervention

My particular interest is in the benefit I've found in involving children in these counselling interventions. It helps children to have available to them an independent person. This allows them permission to feel and express their experience in the context of some safety, and provides an arena for the child to have a voice. For the child, it can be a lifeline to have an independent authority figure who names the problem, affirms the child's individual perception and understanding, and provides an environment of safety.

When children have lived in violent family situations their emotional accommodation of the situation can cause confused and distorted perceptions. In working with these children, there is a need to focus on a range of experience: for example they can feel guilt, anxiety, anger, confusion and sadness about their family situation. Frequently, they have ambivalent feelings about each parent. Children can love their father, but disapprove of his violence. They may feel sorry for their mother, but also resent her helplessness and inability to protect herself and them. The exposure to violence over time results in modelling of violence as an appropriate way to resolve conflict, and children at latency age and in adolescence may identify with and mirror their father's attitude toward their mother. Often children are frightened by their own anger and feel that the cycle of violence is inevitable. They can feel responsible for having caused the violence. Their perceptions though false and exaggerated, can result in low self-esteem and self-blame (Jaffe et al). The individual work with these children focuses on clarifying some of this confusion.

Providing structured intervention ensures accountability and child focus in the parents, away from their relationship drama. The intervention provides the parents with independent feedback about the child's experience, perceptions, feelings, strengths and coping. It provides the counsellor and the Court, if reportable, with information about the family's dynamics and the child's experience of the violence and abuse through the child's account. The benefit of these interventions are maximised and ongoing if the child is assured of safety, and the accountability and responsibility of the parents is maintained.

Therapeutic Qualities

In recent years psychological theory of abuse has expanded providing language and theoretical frameworks to explain the experience of abuse. I have been influenced in my thinking by Pynoos and Eth's work on children and trauma, and more recently by Judith Hermann and Bessel van der Kolk's work on trauma and the impact of sustained abuse on individual functioning. However as well as an understanding of the dynamics of abuse, we bring personal qualities to our clinical work which we can underestimate or overlook. Connection with the child is crucial to healing and that connection is only made through our personal capacity for compassion and empathy. Feeling accepted and feeling understood are key elements to allowing a person/child to open up, to be confident to share their fear and pain. To share these experiences is to place oneself in the hands of another person. To do that there must be trust and confidence that that person is safe, that that person can cope with what you are about to disclose, that they can understand, will not judge, and will assist you from a point of fear, shame, hurt, hate, to understanding.

Therapeutic Model

Pynoos and Eth describe an interview protocol for interviewing children who have been witness to violence, which they aptly term "psychological first aid". The interventions trailed follow a similar format.

Interaction with these children involves simple and direct discussion, using drawing, and analogy to focus the process. Connection is established by open, general discussion about the purpose of the counselling, their family construction, age, school etc. Focus is established by naming the problem, and offering openness and support to look at what happened. I may share my experience of other children who have gone through similar experiences, and if relevant some of my own childhood experience. Once trust and rapport are established, the child is encouraged to describe in detail what they may have witnessed or experienced, how they felt at the time and how they feel about it now.

The aim is to avoid minimisation and denial by naming and describing the experience. Reliving and recounting the experience assists emotional release. The experience is reframed in terms of issues of accountability and reality testing of real options for action that were and are available to the child. Closure focuses on the realities of the current situation, viewed from a new perspective and, hopefully leaving the child with a greater sense of inner security. If the child feels free to talk about the experience, express real feelings, assign responsibility appropriately, and set limits, they have achieved a degree of health and empowerment.

Typology
Identified are 3 categories of child experience that commonly present which influence the direction and outcome of the intervention:

1. Children who are presently in crisis and unsafe. *(Violence, threat and intimidation are ongoing in separation.)*

They may present as actively distressed, often dissociating and usually accommodating of the abusive parent. For example, a six year old girl who in the three years since separation had witnessed violence, threat, and harassment of her mother, possible physical abuse of herself, non-return after access requiring police involvement and was a secondary recipient of the violence. Her account of the most recent incident, which she recounted at each contact, was “when I don’t want to go he gets really angry, he tries to kill (step) dad, he nearly killed Mum and the baby, but he mainly wants to kill me.” She believes that it is her fault, and that if she behaves it won’t happen again, “I have to go (on access) - if I don’t do anything wrong he won’t get angry.”

She has moved from feeling that she has a right to refuse access, to fearful accommodation of her father. With no safety assured, despair and nihilism have resulted from the prolonged risk and abuse “Nothing makes any difference, but I feel good talking about it”. The therapy was some help to the child, providing opportunity to talk about the experience. Reassurance and affirmation of her perceptions was combined with some reality input, but the value of the intervention is limited and the integrity of the therapy is compromised if safety is not able to be assured. Recommended management would be to assure safety by allowing “time out” with no contact while the situation, in particular the father’s capacity for constructive contact, is assessed.

2. In crisis, but safe. *(Threat and harassment are ongoing in separation, but the mother has refused contact.)*

These children present with far greater confidence, and sense of the right to self determination. A five and seven year old brother and sister who had had no contact for the three months following separation were able to recount their experience and assign responsibility, describing the conflict: 'Daddy got angry and pushed Mummy through the screen door.' 'Daddy gets angry and starts to fight and hurts Mummy'. They are aware of and feel confident to express their feelings: 'I feel scared when Daddy is silly' 'when he pushes her over I feel bad because I can't do anything about it'. They feel confident to set limits: "sometimes I want to see my dad and sometimes not. I don't want to stay overnight, I feel scared and would be worried if I woke in the night." Both children expressed some curiosity to reconnect with Dad, but within a self-determined and secure framework. In this instance, the monitoring occurred over 6 months. The contact continued to be problematic as this father had limited capacity for containment and responsibility taking, and the mother increasingly had difficulty in setting limits.

3. Not in crisis, safe. History of violence and abuse. *(Physical violence has not been an issue post-separation, but control and manipulation of the child through contact are the risk.)*

A pre-adolescent who had witnessed and was victim over many years to some severely violent episodes. He presented as accommodating his father and minimising and denying the violence. The child described a recent assault of his mother and physically abusive treatment of himself pre-separation, but minimised the experience saying "Dad is not angry now". The risk was that he would accommodate his father's denial of the violence, in turn become aggressive with his mother, while continuing to internalise feelings of confusion, fear and anxiety. The contact arrangement commenced, by agreement between the parents, with minimal day contact, monitored and reviewed over 6 months and was increased to standard weekend contact only at the end of that 6 months. The therapy was able to give some reality to the abuse and allowed the boy to distance from his father's manipulative strategies. Though the therapy was limited in resolving the trauma, the child was less vulnerable to coercion.

Conclusions

Determining the violence and ensuring safety are difficult challenges for the Court, but are prerequisites for realistic child protective response. The interventions trailed can allow to some degree for a child protective and child focussed systems' response. I have found there has been benefit, in particular for the children, in this work with these families. By involving all family members the family system is assessed, family interaction is monitored and options for change are processed and trailed over time, at the same time providing some brief therapeutic intervention for all family members.

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