

*Through the Kaleidoscope:
An Emerging Model of Working With Families Affected by
Sexual Assault and Domestic Violence*

*By Laura Luchi and Deanne Dale
Wentworth Area Violence, Abuse & Neglect Prevention Service*

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Thank you!

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This paper describes the development of a model of clinical practice with children, young people and their families, where the effects of sexual assault and domestic violence are presenting difficulties. In order to develop this model, two services have been endeavouring to overcome differences in policy and perceived differences in clinical approach and orientation.

What has supported this development is a structure that delivers service across a “continuum of care” for all people affected by violence, abuse and neglect in the Wentworth Health Area. It has also been helpful for counsellors to participate in family therapy training together. This has encouraged conversations with children, young people and their families about a range of violent and abusive experiences and practices that had not previously been possible, while also allowing for individual therapeutic work as required.

There have certainly been some challenges in finding the common ground necessary to work this way and it has been a process that has evolved over more than two years (and is still in progress). This paper shall describe what we have learned along the way that is shaping our service and may assist other services considering this direction.

INTRODUCTION

In NSW, at this point in time, Health services are working to overcome the obstacles of fragmentation and compartmentalised thinking in their development, to work together in a real and on-going way. This paper describes how Wentworth Area Health Violence, Abuse and Neglect Prevention Services has been endeavouring to develop a “joint work” model between the co-located Sexual Assault Service, providing services to adult and child victims of sexual assault and the PANOC (Physical abuse and neglect of children)* service. It describes how the services have managed to maintain the integrity of their individual identities, while developing a “we” identity as a direct services team and a new model of service delivery. Instead of looking at our work through one particular lens, we can now look through the Kaleidoscope, incorporating many ideas and understandings.

*[PANOC provides services to children and young people who have experienced PANOC within their families; typically within the context of what is known as “Domestic” or “Family” Violence.]

THE HISTORICAL CONTEXT

Sexual Assault and PANOC services in NSW have had different geneses and thus historical influences. Sexual Assault services had their genesis in the feminist momentum of the 1980's out of which sprang a range of NGOs specialising in this area eg, CASAC services, oriented to children and young people, and adult oriented services eg, Rape Crisis and Dympna House. Also established were NSW Dept. of Health services offering crisis, medical and on-going counselling services.

PANOC services, on the other hand, were established in the late 1990's in response to recommendations from the Wood Royal Commission and Child Death Review Team, that highlighted large gaps in service delivery; particularly those described as tertiary. The 17 services established around the state are situated in a wide variety of settings, both hospital and community based and have consequently developed a wide range of processes and practices. What is fundamental, however, is that these services will only accept referrals from NSW Department of Community Services (DOCS) with an allocated Child Protection Caseworker and provide medium to long term services.

THE IDEOLOGICAL CONTEXT

In the wider context, many interesting processes have been occurring within the professional community around the knowledge and thinking about sexual assault, domestic violence and child protection. Practice, research and thinking have for some time begun to acknowledge the relatedness of different forms of violence (Tomison, 2000). Over time 'we' have noticed that Domestic Violence and Child Protection issues are 'becoming present' in the context of Sexual Assault and indeed that Domestic Violence is a crucial aspect of Child Protection (Laing, 2001). The 'radically feminist' history within which Sexual Assault has been stereotypically embedded and the highly 'medicalised' context Child Protection has been historically associated has been faced with the challenge of finding a common ground and language to describe the emerging reality of working with violence and abuse.

THE ORGANISATIONAL CONTEXT

In 1997, Wentworth Area Health Service established a Child Protection Support Service, employing a co-ordinator, trainer and clinical consultant to initiate a process of making Child Protection an issue of concern across the Area. Around the same time the PANOC service funding was approved, the service co-ordinator submitted to the Area that all service provision pertaining to violence, abuse and neglect should be managed through one point to ensure services would be effectively co-ordinated and able to be integrated. This was consistent with policy directions in NSW Health that were being influenced by the research highlighting the interrelatedness of different forms of violence and their impacts on people's lives.

The VAN (Violence Abuse & Neglect) Prevention Services Model was thus developed, also incorporating the Sexual Assault Service, new Health Improvement team and Clinical Consultants, to provide a range of services across the "continuum of care" for people affected by violence, abuse and neglect with a strong focus on capacity building and developing internal and external partnerships.

For the Sexual Assault and PANOC teams, now known as the Direct Service Team, the model implied the joining of teams, previously perceiving themselves to be distinct, into one tertiary service with the additional mandate of domestic violence.

THE SEXUAL ASSAULT SERVICE EXPERIENCE

Leading up to the restructuring of PANOC and Sexual Assault, the Sexual Assault Service experienced a reduction in human resources and began struggling with heavy community demands on existing resources. This raised much anxiety and many questions around how we would cope with increasing waiting lists and continue carrying out our core business. The coming together of these two teams also produced anxiety around our ability to maintain an identity as a service and our relationship to the statewide network of Sexual Assault Services. We wondered how we would make our presence felt in the community when we were experiencing the restructure more as an assimilation process. Needless to say, there were many tense moments.

Concurrently, the Sexual Assault team were finding that increasingly, ‘other’ forms of violence, abusive practice or lack of safety in the child’s home environment was undermining the therapy they were doing with children. Sexual Assault policies did not recognise the dynamics of sexual abuse as often occurring within the context of other forms of violence. Therefore, there were no guidelines to inform practices when these situations arose and more often than not services would be terminated and clients referred on to other services; an unsatisfactory outcome for clients and workers alike. The team had begun thinking about letting go of old ways of knowing and adopting the spirit of a changing view of violence which was more holistic, paving the way for exploring working with the PANOC service.

THE PANOC SERVICE EXPERIENCE

Being a new service, with scant guidelines for clinical practice from NSW Health, PANOC have been able to tailor their developing service to the client needs in the Wentworth Area. There were few impediments to considering joint work with the Sexual Assault Service. Indeed it was welcomed, given that the PANOC service was established with inadequate funding to meet the demand for service from local DOCS offices and has continuously struggled with a large waiting list.

The PANOC service, with a mandated child protection brief (including Child Sexual Assault in this understanding of the term “Child Protection”) had always been working with families where sexual assault was “present” and included in conversations with children, young people and their families. PANOC had a large proportion of adult clients who were involuntary or semi-involuntary with a brief to discuss the effects of their abusive practices on children and young people.

The PANOC team was thus attracted to the idea of having a “zoom lens” (Burke, 1999) approach to their work wherein the context in which the family lives is taken into consideration when discussing how violence and abuse is present in families, what effect it has on family members; particularly children and young people. Most importantly, who is responsible for the violence and what needs to change to keep children and young people safe can be articulated and translated into goals for the work.

COMING TOGETHER – the “Joint Work” Journey

CO-LOCATION

Inevitably, there was a long period of adjustment and certainly some resistance to change. The SA and PANOC Teams were co-located for several months prior to the formal re-structuring that took place with little communication and a lot of tension during that time. However, a couple of issues became apparent. Firstly, that a number of clients were being referred to both services and secondly, the issues arising in the assessment and therapy process did not always fit neatly into the categories of violence imposed by the system we were working within. These categories rendered invisible other forms of violence. There was disparity between the complexity of our clients lives and the systems understanding of violence, the latter of which informs our services directives. This disparity between our service directives and our experience and observation of clients realities began a dialogue that would culminate, two years later, into what we now refer to as Joint Work.

THE IMPACT

Part of this restructure involved the creation of Clinical Co-ordinator positions for Sexual Assault and PANOC (now known as Team Leaders) who were responsible for the day to day functioning of their teams, intake processes and clinical supervision of team members. Team Leaders were given a prime directive - “be a direct services team”. At this time, Sexual Assault were struggling with the loss of a full time manager, a full time intake co-ordinator, counselling positions and a brand new, relatively inexperienced and much smaller counselling team. PANOC were struggling with changing clinical processes and inadequate human resources, making the task of service provision rather challenging. In addition, both PANOC and SA were coping with heavy caseloads and long waiting lists. How to follow the prime directive?

JOINT MEETINGS

The first strategy employed was to institute monthly meetings to decipher the meaning of the “Joint Work” directive. Over time it became apparent that many individuals in both teams were operating from different ideologies, therapeutic backgrounds and disciplines. We needed to find a common ground to break down some of what seemed to be *perceived* difference. The PANOC and Sexual Assault Teams noticed there were a number of differences, resulting in lack of understanding of our colleagues in relation to team policies, understandings of abuse, goals and outcomes and ways of working with children, adults and families.

We set about a process by which we communicated to our colleagues the workings of our teams, and came to know each other as professionals with varied and equally valuable perspectives, working in the area of violence and abuse. As a consequence, we also came to know each other a little better as individuals venturing into the uncharted territories of approaching different forms of violence in families from a multifocussed perspective. We identified what we do that can be regarded as “Common Ground” and noticed that essentially, we were all working with the effects of abuse on families or individuals.

FAMILY THERAPY TRAINING

The second major strategy employed was joint team in-service training. We employed external specialist trainers in groupwork, and in counselling children and young people around serious problems; which enhanced the joint team explorations as outlined above. However, what was missing was an over-arching framework within which to explore the identified common ground and be inclusive of individual ideas and values. We hoped that common understandings and language would eventually develop. After much discussion, a systemic paradigm was deemed to be the most appropriate to explore.

V.A.N. Prevention Services employed Relationships Australia to develop and deliver training tailored to our current needs and goals. We had four training days with two trainers from the Resources for Adolescents and Parents Programme (RAPS). Relationships Australia had their work cut out for them. The training proved to be not only a process of learning but also very much a process of coming to terms with truly being a joint team, with a systemic view of intervention. The majority of the training was spent unravelling and deconstructing what systemic intervention meant in the context of violence and individual's therapeutic practice. This was not surprising given the variety of theoretical perspectives that informed the team members practice.

UNRAVELLING AND DECONSTRUCTING THE SYSTEMIC APPROACH

Language was one of the areas creating difficulty. Some team members thought that the systemic language was too "scientific" and "outdated" and often inconsistent with preferred understandings / conceptualisation of a client's presenting problem. Although there was not one unified way within the team of approaching understanding clients issues, the presented Milan and Post-Milan systemic approach to defining what happens in families struggling with problems, did not seem to fit with anyone!

Further difficulties arose in the described systemic view of the family hierarchy and the practice of addressing the adult male first in an attempt to engage the "most difficult to engage" family member. Objection to this practice was around what implications this may have in a service where women clients have been violated and abused mainly by adult males (of particular concern to the Sexual Assault team). As services that approach our work with families from a child protection focus and attempt to achieve egalitarian practice rather than promote non egalitarianism, it became clear that this was one aspect of the systemic model that would have less influence in the development of our model.

Of particular interest were the dialogues between "systemic" thinkers and "post structuralists". These conversations were around how important the meaning making process in therapy can be and how "knowledge" about clients lives is understood and constructed. These conversations helped to stimulate ongoing discussions around our assumptions, our "expert knowledge" and what it means to "know".

Furthermore, we discussed how to address the power imbalance in therapy and how to promote practices that acknowledge and attempt to redress this. For example, the notion of developing a hypothesis/es about a family based on assessment information gathered prior to meeting with them seemed outrageous to some. Many felt this practice diverted from the predominant belief that the client informs the therapeutic practice by providing the material with which we as the

therapists work in tandem with our clients. There was a consensus that our model should base our “hypothesising” on comprehensive information gleaned from the family.

Another concept the team spent time considering was the understanding of what and who is the problem - in systemic therapeutic language the “IP” (Identified Patient/Problem). We questioned whether or not this was relevant to working with families where abusive practices were common – is there a “victim” and a “perpetrator” and are either of these the IP? Indeed, how useful and respectful is it to think about family members this way? In our case, we felt that this conceptualisation categorises violence and does not acknowledge its complexity in a family context. We can operate without an “IP” in a child protection framework by having the safety of children and young people as the focus (or the IP if you like).

We also explored different types of questioning –“circular”, “other oriented” and so on. We questioned how this fits with our client group when the session content is mostly about violence. We asked ourselves; Are these forms of questioning sensitive enough to a client’s personal experience of being abused and how appropriate is it to ask family members to share information in this way? In the end, we were most impressed by this particular aspect of a systemic approach. Although there was some initial difficulty around the perceived surreptitiousness of some types of questioning, with a little reframing and approaching questioning with different intentions, we have found that these are powerful tools in assisting families and therapists to understand each other and develop empathy.

On the last day of the training we were invited into a series of exercises that assisted us in developing our model:

1. An exercise that highlighted different understandings and responses to change and what this may mean for changing practices.
2. An exercise that assisted us to identify what areas would need to be more closely examined and worked through in joint meetings including; “Shit, where do we start?”, Differences in services, frameworks, meaning, ethical and political positions; Approaches to the work and the implication for workers, clients and policies; Practicalities, including time, resources and case management; Evaluation of the model
3. A role play exercise using the scenario of our “Case Study” family to help us start thinking of engagement practices and how to describe our emerging model to families.

Overall, the team as a whole took on board the spirit of systemic intervention; team members thought they could adopt some techniques, remodel others. The experience of spending four days in four consecutive weeks together as a direct service team was not only fruitful professionally, but provided a space for individuals to begin feeling like we were really onto something exciting and we were doing it as an integrated group.

THE MODEL

DEVELOPING GUIDING PRINCIPLES

Of our many thoughtful conversations in this journey, team members were attracted to these ideas:

- Seeking a model of working with families that reflects the values of our team including both client and therapist being treated with **integrity** and **respect**.
- Attempting to understand our clients world **without imposing judgements**
- Developing a way of being with clients that is **flexible, client centred and able to acknowledge different forms of violence**.
- Demystifying therapy and inviting clients to participate in a process that they have entered into by **informed choice**.
- Validating client's expressed needs, experiences and beliefs **without colluding with and / or justifying violent and abusive practices**
- In a field where professional discourses around confidentiality dominate, clients often remain uninformed of the decision making processes involving themselves and their future. The nature of physical abuse, neglect and particularly sexual abuse is such that those subjected to it are often threatened overtly or covertly to remain silent. The secrecy that surrounds abuse and the accompanying fear of disclosure can become a powerful and long lasting legacy within the family. In openly sharing our ideas, information and methods of working, we hope to create an environment where honest and clear communications can be encouraged. We feel that **transparency** is an essential aspect of working successfully and honestly with families.
- In line with the practice of transparency, actively **including families (as well as children) in decision making** as much as possible is important. Our work is informed by clients in relation to their needs and what will work best for them in terms of intervention. We hope that by doing this, we facilitate a sense of their ownership of this process, hence commitment to it and credit for its success.
- We are committed to the idea that we are primarily **accountable to our clients** for the quality of our work and therein committed to workers having **appropriate support and resources** to do this work, including time and supervision.

The model of family therapy currently in development could tentatively be described as a systemically informed, client focussed and directed model.

STAGES

PRE-PLANNING

In the initial period, once the family has been allocated to a PANOC and sexual assault counsellor, the counsellors and team leaders meet to negotiate how to approach the family. Numerous variables are taken into consideration including the therapists' orientation and conceptualisation of change, the families presenting issues of violence and the resources that are likely to be required.

Discussion between therapists around their understanding of the issues specific to this family and their general approach to therapeutic intervention is encouraged within initial meetings and on an ongoing basis in supervision. Where there are irresolvable differences in understanding and approach, we have the option of reallocating to a different counsellor however this has not yet occurred.

During the pre-planning stage, agreements are made around supervision – it's frequency and duration and attendance by both therapists and Team Leaders. The two therapists and Team Leaders attend regular group supervision. This can occur anywhere from weekly to monthly depending on the therapists needs and the complexity of the family circumstances. Supervision generally involves discussion around the meanings and understanding of processes occurring for the family, potential interventions and possible changes to the current structures and practices in working with the family. It has also been extremely important to address the therapists experience of working jointly with another therapist in this relatively new area.

Finally, administration details are negotiated. Due to legal and policy requirements, we maintain one file with three sections –one belonging to PANOC one to Sexual Assault, and one titled "Joint Work". Therapists have found that writing notes jointly has been a productive endeavour. At this point, a central contact person is also identified for the family. We have found that this simply makes it easier for families and therapists in avoiding confusion.

ENGAGEMENT AND INFORMATION GATHERING

Therapists make agreements as to who will play which role in the first session. It is a given that both will openly participate in sessions however we have experimented with what have come to be known as the "listener" and the "talker" roles which alternate each session. The talker directs the session based on pre-session discussions with her colleague. The listener sits with the group, positioning herself so that she is visible but not uncomfortably present and not sitting behind anyone. The listener introduces the session plan or goals (such as "We'd like to understand a little more about X today") and takes notes with the families agreement.

The listener can participate in the session by asking a question or commenting, with the talkers prior agreement. It is also envisaged that we may be able to work with large and "busy" families by having one worker focussed on the adults, while the other focuses on the children, to ensure they have a "voice" in the work. There is often the risk that the children's needs and ideas are subsumed by those of the adults in the family.

During the initial sessions, therapists work on developing a comprehensive picture of the families history and current circumstances. Loosely structured session plans often involving art or play activities are developed for this purpose and areas that emerge as pertinent are also explored. The focus of this time is on information gathering and relationship building. We have found in our experience, whether it involve individuals or groups, that the beginning stages of the therapeutic relationship developed with a client will “make or break” the therapy. Unfortunately, we have not found a way to speed this process! It seems to take on a life of its own and it takes *time*.

A further purpose of this stage is for the development of the therapist to therapist relationship. We have found that allowing ourselves room to develop a working relationship and understanding of each other in the therapy setting has allowed for the development of harmonious ways of working and hence effective interventions for clients. In line with our appreciation for the difference and individuality of each client and family, we understand that an ideal therapist/therapist relationship will not necessarily replicate itself in the context of a different family, hence this stage of the process is considered essential.

OPEN HYPOTHESISING AND EMERGING NEEDS

Following the engagement and information gathering stages where a meaningful picture of the family has been developed, therapists may offer some understanding or hypotheses around specific issues that have been identified as maintaining unhelpful patterns of behaviour or abuse or influences standing in the way of healing and non violent practices. These are openly discussed with the family and family members are encouraged to contribute to these possibilities. In addition, possibilities around how individual experiences and effects of violence are impacting on the family are explored.

Here it is important to ask questions that permit the “zoom lens” approach to operate as previously described. This is particularly important when mapping the impacts of the abuse and the “invisible man” (Burke, 1999) or indeed “invisible men” that are responsible for it, but are usually not available to be made accountable. The shame, guilt and over-responsibility carried by members of the family (usually women and children) can then be named and worked with. Socio-political and other cultural contexts can also be incorporated into conversations about the experiences and understandings of problems.

Within this work, therapists can also “zoom in” to address the emerging needs of individuals within the family system. Negotiations take place around how best to meet these needs. Where children request individual time or therapists request this of children, conditions and times are agreed upon in the family context. The general “conditions” that apply are that the children will decide what information may or may not be shared with the system from individual sessions. Children are also given the opportunity to decide who will attend their session. We ask that following the first individual session, the family participate in a discussion around the experience of separating. The same conditions apply for adults where they request or are requested to participate in individual time. Given that each family is referred to PANOC as a whole family and individuals within that family are referred to Sexual Assault, clients are given the option to spend individual time with the specialist worker.

This way of working has allowed for personal or individual issues to be addressed comprehensively and have found that it is crucial to provide clients with this opportunity. Often, situations arise where it is clearly inappropriate and potentially damaging for clients to share information with the family such as with adults who commonly find that their own abuse experiences are being triggered by the therapy. Individual time gives clients this space to express themselves without restraint or concern for what the children may be exposed to.

In the instance where family related issues are raised, particularly by children in an individual context, children are encouraged to explore the benefits and/or costs of inputting this information into the family system. The therapist in this situation always considers the safety of the child. Following individual sessions, where possible, the family re-groups if only for a short time simply to maintain the focus on the family system.

CHANGES TO PRACTICE

Perhaps the most powerful effect of developing a new approach to working with families in the context of violence has been the “permission” to be and work differently with people thus expanding the therapeutic agenda and intent. Our perception of the effects therapy may have on an individual child has changed dramatically with the understanding and acceptance that every child is living within systems - effecting change is as much about working within those systems as it is with dealing with the individual effects of a traumatic and/or abusive experience.

This understanding has been particularly relevant to the sexual assault team who have traditionally worked in isolation with adults and children, sometimes due to a lack of knowledge about working otherwise, sometimes due to fear of working otherwise, and sometimes due to the lack of energy that comes along with an ever expanding caseload. At times however this has been in response to the dominant belief that child sexual abuse is private and confidential and the fewer people beyond parents that become intimately involved the better.

For a long time, this belief has been based in a fear of stigmatising the child and perhaps unwittingly wielding our therapeutic power, hence pressuring a child to share their experience with others (such as siblings or grandma) in response to demand rather than will. In changing our practice, we have allowed our clients the opportunity to have their individual therapeutic space as well as “family” therapeutic space, which among other things has allowed pertinent information to be explored and shared within the system as directed by the client to bring greater understanding and meaning to the family.

CONCLUSION

In tandem with the changing conceptualisations of violence within the broader professional community, the Wentworth Area Health Service was able to implement the Violence, Abuse and Neglect Prevention Model, which comprises a comprehensive and integrated approach to health care. At the service level where Sexual Assault and PANOC operate, fertile ground was provided for the frontline workers to take on board these trends and directives and create this model.

This experience has occurred over a period of over two years and has involved hundreds of hours of meetings, negotiations, brainstorming, training and diving into the unknown. Our model of

we prefer to view this mode of working as an ongoing creation within a structure, informed by our clients and colleagues and continually subject to change and improvement. We do not really know how this model will have evolved in a years time nor do we wish to determine that at this point in time. However, we can now look “through the Kaleidoscope”; bringing our clients ideas and knowledge together with our “professional” knowledge and experience in specialised areas of sexual assault and domestic violence to form a rich, colourful and dynamic model.

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