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COURT ORDERED THERAPY: MAKING IT WORK

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This is an interesting, professional-level article. I was left wanting to know more about the program. The author shows sophistication in the issues that arise in the course of court ordered therapy and also in effective ways to resolve them. An important aspect of this article is that it deals with a case of physical abuse. In the current climate, this important life threatening problem tends to be somewhat neglected in favor of the more sensational issue of sexual molestation. It is important to maintain an awareness of physical abuse as well as sexual molestation. I would like to see the author do a book.

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The exigencies of court ordered treatment counter some of the principles we learn as psychotherapists. The court ordered client, who has no legal right to confidentiality and comes to therapy only under duress, presents a dilemma for many therapists. Yet the courts are increasingly ordering probation with counseling or psychotherapy for a number of offenses ranging from drunk driving to child abuse, considering this to be a more viable route to rehabilitation than incarceration. Successful completion of probation and other outcomes, such as reinstatment of driving privileges or return of a child to his parents by the juvenile court may be contingent on the successful completion of a course of psychotherapy as determined by the therapist's evaluation to the court.

There is much controversy about the effectiveness of court ordered treatment with substantive arguments to support the positions of both opponents and advocates. Despite these disagreements, court ordered therapy has been found to be helpful in protecting abused children and rehabilitating their families.(6) The court can serve as a catalyst for getting services to families who are reluctant to seek them out(1,5,9,10) and for ensuring that families remain in treatment through resistant phases of therapy. Court orders can further protect the rights of parents by specifying the criteria for therapeutic success.(3)

That the concept of court ordered therapy has only begin to be formally examined is evidenced by the lack of literature on the subject. While offering no final answers, the Children's Hospital Trauma Center has been providing counseling for over ten years to families in which child abuse has been a problem. The majority of parents coming to the Center are ordered there by the juvenile and/or criminal courts and come to treatment involuntarily. We have, out of necessity, developed a number of

techniques for handing this situation. The resistance to court ordered treatment must be addressed and appropriate goals for treatment developed on which the client and therapist can agree.

The court ordered client has no legal right to confidentiality, yet his rights must be protected as well as the rights of past and potential victims. The courts customarily require progress reports from the therapist and will not refer clients to therapists who are unwilling to provide such reports. I will thus elaborate on our methods for handling resistance and reporting to the court with the expectation that some of these approaches can be generalized to court ordered therapy situations other than child abuse.

Resistance to Treatment

The court ordered client comes to treatment under duress, and frequently presents a well developed denial system. A court mandate can, in theory, be a useful treatment tool for dealing with denial by getting parents to recognize their problems and work toward a solution.(2) This has not generally been our experience with abusive parents entering therapy who frequently deny that abuse has taken place. Their goals commonly include staying out of jail, getting rid of "the system's" intrusion in their lives, and getting their children returned home. These goals are not always consistent with the court's goal to rehabilitate rather than punish the family.(1)

In order to accomplish these goals, the court must specify services and needed changes in parental behavior to prevent further maltreatment.(5) Where determined to be clinically appropriate, the Trauma Center uses treatment contracts which specify behavior changes, presented in positive terms, considered necessary for the successful completion of therapy. This clear delineation of treatment goals has been accepted so enthusiastically by our local juvenile court that they have come to rule more favorably in all Trauma Center recommendations [see Appendix A)

Establishing a therapeutic relationship with clients who come under duress and view therapy as a type of prison sentence can present problems. Treatment must be considered in the context of the parent whose dependency needs, low self esteem, and anger have played an important role in the etiology of the abuse.(2)

The therapist must attempt to separate himself from the court system and clarify that the goal of treatment is not to establish guilt or innocence as this issue has already been decided by the court. It is crucial to remember that the client, not the therapist, is the one who is court ordered and must assume responsibility for successful compliance with that order. The client must be given a clear choice about his role in treatment.

Despite the axiom that an individual must be motivated for psychotherapy for any change to take place, research on the subject has not shown a strong correlation between initial motivation and successful outcome. Motivation is undoubtedly subject to modification through therapy as are other aspects of the individual.(7)

The engagement phase of therapy with the involuntary client is, in our experience, more extended, usually taking anywhere from two to six months. We use a variety of techniques to facilitate engagement with the court ordered client. Initially, we attempt to meet basic and unmet needs. It is important to convey realistic confidence in ourselves as helpers. We accept resistance and deal directly with it. After explicitly clarifying and formulating role expectations for worker and client,(11)we try to establish a variety of goals on which the client and therapist can agree. These can sometimes be developed when clients relate problems during history taking or from process observations made by the therapist. Material can be taken from the treatment agreement if the client agrees. Our clients have sometimes suggested appropriate goals when asked what they would work on if given a course of psychotherapy as a gift. Once common goals are established, therapy can proceed more effectively.

Confidentiality

Our training as psychotherapists stresses the importance of maintaining privacy regarding material presented during the therapy hour for treatment to be successful. State laws reinforce this concept by mandating that communication between patient and psychotherapist is confidential, with the patient holding the privilege for that communication as a constitutional right. However, "There is no privilege under this article if the psychotherapist is appointed by order of a court to examine the patient."(12)Not only does the court ordered client lose his right to privacy, but the courts generally request reports on a client's progress in therapy to verify that the client has complied with the court's plan.

At Children's Trauma Center we have agreed to provide progress reports to the courts in the interests of protecting our primary client -- the abused child. The subject of confidentiality is discussed with all families during the first treatment session. Court ordered clients are informed that they no longer have the legal right to confidentiality but are assured that only information relevant to the issue of child protection will be shared with the court. They are further assured that this information will be shared in only the following ways. When court workers call, the sole information given by phone is attendance. Letters to the court, generally required for juvenile court reviews, will be sent only after they have been reviewed and discussed with the client (assuming the client's attendance is sufficiently regular to make this possible.) Any other information will be shared only during conferences between the client, therapist and court worker.

Clients rarely raise objections to the above conditions. We have further found that once clients have engaged in treatment, the limits on confidentiality do not appear to inhibit treatment. Those clients with whom the therapist draws up treatment contracts generally agree that these contracts should be shared with court workers as evidence that the client is meeting the conditions of the court order. We have found that letters to the court can, in fact, be of value to the client as they tend to serve as a report card on the therapeutic process clarifying the client's progress and goals.

Adhering to the principles of structural family therapy, approaching man in his social context,(8) we have come to view the court as part of the larger environment which impacts on our clients and their families. Thus, we view case conferences as potential opportunities, where appropriate, to influence that environment. Experience has shown us that these conferences give our clients a sense of empowerment as they are able to take more charge themselves of the reporting process. Finally, we have found that such conferences can be models for open and clear communication as well as cooperative work together.

Application

The following case example is chosen, not because it typifies Trauma Center clients, but because it provides a good example of our work with both the criminal and juvenile court systems. It is in fact one of the most extreme cases of child abuse ever treated at the Center and one of a small minority in which a successful treatment outcome has not included family reunification.

Three-year-old Tommy B. was admitted to Children's Hospital with head injuries and died on February 14. His younger sister, Shelly, was taken into protective custody and found to have both fresh and healed burns on her legs. The children's mother and stepfather were arrested for murder. Shelly was placed in foster care with a maternal aunt by the juvenile court.

Ron and Emma B. entered treatment on the advice of their defense attorney the following July. They saw a Trauma Center therapist for four months during which time they dealt with mourning issues and insisted their innocence was proved by the support Emma's family was giving them. No reports were made as the couple was not court ordered. On one occasion, lack of space necessitated seeing the couple in a room equipped for videotaping. Although the couple was shown that the equipment was disconnected, Ron became very paranoid during the session and refused to continue therapy. Outreach attempts were unsuccessful at reinvolving the couple in therapy.

Through a plea bargaining arrangement, the couple was sentenced to eight months in county jail to be followed by three years probation. A condition of probation was the successful completion of a course of psychotherapy which was also a condition of the juvenile court plan to reunify the couple with their daughter.

After their release from prison, Ron and Emma again requested treatment at the Trauma Center to meet the conditions of their probation. They were informed that our prognosis for reunification with Shelly was extremely guarded. The Center's typical confidentiality contract was not only discussed but presented in writing to the couple, to both of their probation officers, and to Shelly's juvenile court worker.

Ron and Emma attended therapy sessions for two months. During this time they denied the abuse, appeared somewhat depressed, and were generally mistrusting and uninvolved in therapy despite the therapist's use of a number of engagement techniques.

An identification of common goals first occurred during a session held the afternoon of New Year's Eve. The couple had been fighting about whether or not Emma could go out that evening as Ron had to work. Ron was able to use the session to express fears that Emma would be unfaithful if she went out. It emerged that his first wife had extramarital relationships. Emma was able to let Ron know that clearly he met her sexual needs, but that she feared getting drunk and depressed if forced to spend New Year's Eve alone in their apartment. Ron was able to let his wife go out with family members, and the couple began to realize that counseling might have some value in helping them resolve difficulties as a couple.

Sessions during the next two months focused on strengthening the couple system. Then Shelly's juvenile court worker requested a conference. Ron and Emma prepared to discuss their progress in therapy with her. Shelly's worker began the conference by announcing that she was having Shelly's case reviewed for possible adoption. She then wanted to discuss the couple's progress in therapy. Emma was clearly devastated by the news while Ron acted resigned. The therapist was able to advocate for the couple by helping the court worker understand that further business was impossible following such an announcement. It was further clarified that adoption was only being considered and was not a final probability.

Emma called to cancel the next appointment because she and her husband were separating. However, they were able to meet with the therapist, whom they now viewed as an advocate. During the session they came to realize that their desire to separate was precipitated by the stress of the pending adoption issue. The couple remained together and continued therapy.

Another conference was held in which the adoption issue was clarified as being only a possibility. Emma's sister, who was still caring for Shelly, was identified as first choice for adoptive parent. She agreed to adopt the child, as she was convinced that Ron and Emma had injured the children.

The therapist had told the couple early in treatment that, due to the seriousness of the situation, she could not recommend reunification unless the agency could determine how the children had originally gotten hurt. This would be necessary in order to correct that problem and make their home safe for Shelly. She further shared with the couple that such a revelation might not ultimately be in their best interests, since their couple relationship was built on a strong denial system of the original abuse. The couple now trusted their therapist enough to agree to review the children's medical charts. During an agonizing session in which the couple read Shelly's medical chart, Emma admitted that she had not watched the children as closely as she should have. Ron then became uninvolved in treatment and sat through sessions silently smoking and wearing sunglasses.

Emma requested a private conference with the therapist and her probation officer, Ron agreed to this although the therapist recommended against it, not wanting to disrupt the couple system. During this conference Emma revealed an alarming lack of parenting ability and empathy but shed no further light on the subject of how the children had become

injured. Ron requested a conference with his probation officer during which he revealed fantasies of leaving his wife. Emma then decided to relinquish Shelly for adoption on the condition that her sister be the adoptive parent. Emma subsequently suffered some abdominal pain which dissipated following the therapist's speculation that the pain might be related to Emma's decision to give up her baby.

The therapist's letter, requested by the court for the review hearing, made the following points:

ATTENDANCE

Attendance had been remarkably good considering how painful it had been for the couple to come back to the same hospital where their child had died.

MOTIVATION

The couple had worked hard in therapy and their general functioning had much improved. (They now had their own apartment and both had jobs. They had also developed a supportive network of friends.)

PARENTING SKILLS

While the couple had successfully engaged in treatment, they had not progressed to the point where the therapist could adequately assess their parenting skills. Even though they expressed a fondness for children, they had been unable to deal with issues which must be worked through before their home could be considered safe for Shelly. The therapist was not convinced that his process would ultimately be in the best interests of either Mr. and Mrs. B. or Shelly.

STATUS OF CHILD IN PRESENT PLACEMENT

Shelly appeared to be thriving under the care of Mrs. B's sister, and that maintenance of this placement was strongly advocated.

The juvenile court ordered that the plan to reunify Shelly with her parents be dropped. Mr. and Mrs. B stopped coming to therapy. Mrs. B's probation officer called the therapist to see if the couple had completed treatment. The therapist, who had serious concerns about how the couple would survive giving up their child, said that therapy was not complete. Ron and Emma came back to counseling.

The couple's relationship continued to be stormy during the next several months. They continued to use therapy and even met at the center for sessions, although at one point they had separated. After they reconciled, Ron stayed out all night on Valentine's Day. They ultimately were able to recognize this as a reaction to the anniversary of Tommy's death.

Termination

Finally, three goals were agree upon for termination: (1) Resolve feelings about Shelly's adoption. (2) Gain appropriate perspective on residual feelings from this experience so they do not interfere with future life crises. (3) Stabilize the couple relationship. These goals were achieved during the final five months of treatment followed by Emma's brief urge to get her tubes untied so she could bear Ron's child. He was adamant they do nothing to jeopardize her health as they had suffered too many losses. A final conference with both probation officers terminated treatment with this family.

The couple's resistance to therapy was alleviated when they realized counseling could help them solve problems they had with each other, and when they realized the therapist would advocate for them. The clear agreement regarding confidentiality helped Ron and Emma trust their therapist and more readily reveal themselves in therapy. Case conferences in which Ron and Emma participated promoted a collaborative relationship with the juvenile court worker and both probation officers. This relationship facilitated planning for Shelly and kept her parents in treatment during stressful periods.

The Children's Trauma Center has consistently found that our model of case management can faciliate the successful treatment of the court ordered client.

Treatment Agreement

We have found it useful to weigh the following factors in evaluating the progress of court ordered therapy:

Parents had...

> [1] attended sessions, arrived on time, arrived sober; participated in treatment sessions; followed through on all directives, including therapist-assigned homework tasks.
>
> [2] evidenced a stable relationship, were mutually supportive, were able to relieve each other in childcare and housework.
>
> [3] were able to manage anger and deal nonviolently with the child and each other.
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> [4] were able to tolerate crying, restlessness and negative feelings that the child expressed toward them.
>
> [5] were able to ask for advice on child-rearing.

[6] had been able to utilize nonpunitive, fair and consistent disciplinary measures.

[7] had recognized problems of child-rearing on their own.

[8] had recognized the child as an individual with needs, desires and rights of his or her own.

[9] had indicated positive feelings for the child.

[10] The patient who abused the child had recognized potentially dangerous situations and had been able to remove him/herself from the child at those times.

[11] The parent who had not abused the child had shown that he or she had been able to intervene on the child's behalf.

[12] were able to generate alternate, nonviolent ways of dealing with stress and household crises.

[13] were able to anticipate and handle potential crises.

[14] were able to request and use help in times of crises.

[15] had improved their interpersonal relationships to the point that they had supportive friends.

[16] had successfully arranged babysitting and/or day care for the child.

[17] Major family stressors (unemployment, intrusion into the family of persons who undermine parental authority, etc.) were reduced or eliminated where possible.

N.B. A treatment contract outlining the above points was designed by Karen Saeger and Robert Green at the Redwood Center, Berkeley, California.

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