

**IMPROVING THE HEALTH CARE
RESPONSE TO DOMESTIC VIOLENCE
THROUGH
PROTOCOLS AND POLICIES**

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TABLE OF CONTENTS

INTRODUCTION	1
PAST FAILURE OF MEDICAL RESPONSE	2
EFFORTS TO IMPROVE THE MEDICAL RESPONSE TO DOMESTIC VIOLENCE	6
MODELS FOR BATTERED WOMEN'S HEALTH CARE INTERVENTION	7
WomanKind Model	7
AWAKE Model	8
Shelter Outreach Model	9
JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS STANDARDS	10
FEW HOSPITALS HAVE DOMESTIC VIOLENCE GUIDELINES	11
OBTAINING DOMESTIC VIOLENCE POLICIES	12
PREFERRED ELEMENTS OF A HEALTH CARE PROTOCOL AND PROCEDURE USED TO TREAT VICTIMS OF DOMESTIC VIOLENCE AND/OR SPOUSAL ABUSE IN HOSPITALS OR HEALTH CARE ORGANIZATIONS	15
CONFIDENTIALTY CONSIDERATIONS	18
HOW TO INFLUENCE THE CONTENT OF THE GUIDELINES	19
ROLE OF DOMESTIC VIOLENCE PROGRAMS	20
REFERENCES	22

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APPENDICES

**Appendix 1 - Sample Letter in Response to Inappropriate Conjoint
Counseling Referral A-1**

**Appendix 2 - Sample Letter in Response to Inappropriate Referral of
Victim into Batterer Treatment A-2**

**Appendix 3 - Cover Sheet to National Center on Women and Family Law,
Item No. 54 - Medical Domestic Violence Protocols and Standards A-3**

**Appendix 4 - National Center on Women and Family Law, Item No. 62 -
Couples Counseling and Couples Therapy Endanger Battered Women A-6**

a hospital's chronic pain clinic were found to be abused (Plichta, 1992, p.158), as were 25% of all obstetrical patients (Stark & Flitcraft, 1988, p.302). One study found that women who are beaten during pregnancy are at least twice as likely to miscarry, four times as likely to have babies with low birth weight, and their babies are forty times more likely to die during their first year of life (March of Dimes memo, 6/23/93, p.3). In addition, the Colorado Department of Health reports that the incidence of domestic abuse among disabled women in intimate relationships may be as high as 85% (Mickish, Gaines & Haack, 1992, p.I-5).

PAST FAILURE OF MEDICAL RESPONSE

Yet, despite the magnitude of this problem, the traditional response of physicians, nurses, and other hospital and health-care staff to battered women has been disappointing, although there are some signs of improvement. Doctors in hospitals diagnosed spousal abuse correctly in only 8% of cases in which either explicit information or strong suspicion of abuse was recorded in the women's hospital records (JAMA, 6/17/92, p.3191). Instead of recognizing the battering, practitioners often ignored the physical indications of abuse and treated only the medical symptoms. Alternatively they scrutinized the woman's personality for clues as to the origin of these physical injuries (Plichta, 1992, p.158). Typically, the doctor prescribed tranquilizers, sedatives, or painkillers for her complaints (JAMA, 6/17/92, 3191) or referred her to psychiatric services, particularly if she presented herself as a problematic patient (Kurz & Stark, 1988, p.254).

Battered women were disproportionately referred to psychiatric treatment (*Id.* at p.252). When a battered woman showed signs of psychological distress over time, she was routinely

referred to family services and couple's counseling (*Id.* at p.254). However, therapists have also responded in inadequate ways to battered women. In a survey in which 362 randomly chosen therapists who were members of the American Association of Marriage and Family Therapy read case scenarios of wife abuse, 41% of them missed all of the readily apparent signs of domestic violence, and failed to recognize that domestic violence was occurring in the couple's relationship. Only 2.2% of the therapists recognized that domestic violence can ever be lethal (Harway & Hansen, 1990, p.17). Even when the therapists recognized indications of wife battering, their approach was often inconsistent with current minimal medical standards. Only 27% of the therapists indicated they would utilize interventions that deal with battered women and their safety, such as shelters or the courts (Hansen & Harway, 1990, p.18).

Hospital doctors sent home 47% of the women they saw after being battered without referring them to any domestic violence program, thereby exposing them to further abuse and resulting in further physical and psychological stress (Kurz & Stark, 1988, p.252). As their patient's signs of abuse escalated, the woman's children were often removed from the home, and some women were even psychiatrically hospitalized without evidence of a psychiatric ailment (*Id.* at 254). Clinicians often labeled abused women according to classical stereotypes and regarded their desperate requests for help as "unfeminine" or "unworthy." Many doctors believed that the battered woman could change her situation if she really wanted to, so blamed her if she failed to do so (*Id.* at 256). Furthermore, her repeated attempts to obtain assistance frequently caused her doctors to label her negatively, giving them a rationale to limit her access to any of the resources that she would need (*Id.* at 254). In all, less than 12% of abused women were triaged to appropriate services (*Id.* at 252).

Traditional medical treatment given to battered women sometimes led directly to their receiving additional physical and psychological injuries. Doctors were more likely to give a battered woman tranquilizers and other medication which increased her risk of assault because of decreased alertness. The painkillers prescribed were often chosen without balancing her need for relieving pain with her need to be alert. The prescribed medications also made her more susceptible to drug abuse and suicide attempts, presumably because they lowered her self-esteem by telling her that she was the "sick" one (*Id.* at 252-53).

Given the inappropriate treatment and stereotyping, battered women, not surprisingly, ranked the effectiveness of health care providers below that of clergy, district attorneys, social services, lawyers, shelters, women's groups, and police officers, lower than any other professional group in surveys (Bowker & Maurer, 1987, p.39, 41).

The reluctance on the part of health care providers to treat battered women appropriately and effectively had further adverse effects on the battered women. First, the conjoint and family counseling encouraged by many health care providers usually further endangered battered women (Flitcraft et al., 1992, p.12). Couples therapy encourages the abused woman to examine her role in the abuse, thereby erroneously suggesting that she, and not her abuser, is primarily or even partially responsible for the abuse (Schechter, 1987, p.16). Conjoint counseling wrongly assumes that the woman can control her partner's abusive behavior, at least in part (Hansen & Harway, 1992, p.16). Furthermore, battered women frequently receive retaliatory beatings following counseling or their disclosure of the violence; some women have even been killed as a result (Schechter, 1987, p.16; Lindquist, et al. 1985; Edleson & Tolman, 1992, 103-05).²

² See also National Center on Women and Family Law, Item No. 62, "Couples Counseling and Couples Therapy Endanger Battered Women" in Appendix 4, beginning on page A-6.

In addition, many agencies providing family services, including those provided in hospital or health care facilities, emphasize keeping the children with both of their biological parents. This emphasis on family preservation, defining the family as both parents, is incompatible with the very nature of battering and of abuse. If the woman is to escape the abuse, she must move herself and her children away from the abuser (Schechter, 1987, p.22). Although some social workers and child protective service workers, upon discovering the abuse, tell the woman to leave her abuser, they seldom give her much assistance. However, they readily label her as a neglectful mother if she cannot stop the violence against herself and her children (Schechter, 1987, p.20). The family intervention that they give even to a mother who does not abuse the children, includes a lengthy service plan with many meetings with courts, therapists, guardians, schools, and doctors for their children, requirements that the batterer almost always escapes. These intricate service plans actually or effectively prevent the mother from seeking safety for herself and her children at a shelter or residence outside the region because she must continually appear at and answer to these agencies, thus exposing herself and her children to danger (Schechter, 1987, p.21). Even worse, many women are effectively or actually required to attend couples counseling with their batterers by health care workers or through service plans.

Many policymakers, including those responsible for writing health care policies, wonder if mandatory reporting of domestic violence will help battered women. Yet statutes requiring health care workers to report abuse to criminal justice authorities or even social service agencies are not likely to improve the condition of the battered woman. Reporting does not ensure action and, when it does, it generally triggers the same type of intervention as has been given by child protective service agencies. Because the responding agency is seldom knowledgeable about how

to stop the abuse, the woman risks being ordered to the same type of service plan which is likely to further increase her danger. If she is sent to court, she and her abuser will probably be sent to mediation which, like couples counseling, further endangers her and her children (Schechter, 1987, p.18).

The failure of doctors to diagnose and treat domestic violence appropriately is not surprising given the lack of training on the subject in medical schools. A recent survey of American medical schools revealed that over half of them provided no instruction to any student on any aspect of family violence: child abuse, elder abuse, or woman abuse (Hames, Holtz & Safran, 1989, p.38). What little training was provided was mostly on child abuse, followed by elder abuse, with spouse or woman abuse the least likely to receive any training. The majority of those medical schools which included some aspect of family violence in their curriculums relegated it to less than twenty minutes a year of an elective having fewer than twenty students. Schools for therapists spent even less time on the subject (*Id.*; Conversations with Marshall Rosman and Martha Witwer of the AMA). No wonder health care providers were incompetent to deal effectively with the subject, and why a new approach to domestic violence is needed.

EFFORTS TO IMPROVE THE MEDICAL RESPONSE TO DOMESTIC VIOLENCE

As health care providers began seeing the need to recognize and respond to domestic violence a number of promising efforts took place.

For the past ten years, a small network of American nurses has documented the extent that women are abused by their intimate partners (Campbell 1994, p.6). These nurses were among the first to document the extent that women were abused by their partners during

pregnancy (*Id.* at 5).³ In 1985, U.S. Surgeon General C. Everett Koop first addressed domestic violence as a public health problem (Flitcraft 1994, p.4) telling the health care professions they needed to confront the problem aggressively.

In further response to the seriousness of the problem of woman abuse and the need for the medical profession to address it, the American Medical Association promulgated "Diagnostic and Treatment Guidelines on Domestic Violence" in 1992. Like all guidelines, they are advisory, and not mandatory standards.

MODELS FOR BATTERED WOMEN'S HEALTH CARE INTERVENTION

Over the past ten years at least three promising models for healthcare intervention for victims of domestic violence have emerged: the WomanKind Model, the AWAKE Model, and the Shelter Outreach Model.

WomanKind Model

The WomanKind Model, the first hospital-based program of its kind in the United States, was founded as a nonprofit corporation in April of 1986 to better identify and treat battered women who come into the health care system. WomanKind is based on the premise that health professionals often intervene at a point where domestic abuse can be identified, support and education can be given, and the battered woman can learn of the community resources available. WomanKind provides a supportive connection between the battered woman in the health care setting and the resources available in the community to help her and her family. The program

³ Domestic violence advocates can contact these nurses for consultation, assistance with trainings, literature list, etc., through the Nursing Network on Violence Against Women International through Dan Sheridan, 14980 S.W. 103rd Avenue, Tigard, OR 97224; (503) 494-7207; (503) 494-4357 FAX.

trains all hospital staff to identify battered women and immediately page a WomanKind advocate if it does.

WomanKind was founded with the dual mission to provide: (1) advocacy services, crisis intervention, and ongoing assistance for victims of domestic abuse; and (2) education and consultation with health professionals, WomanKind is located at two suburban hospitals and one urban hospital of the Fairview Hospital and Healthcare System in Minneapolis, Minnesota. Between 60-70 clients are referred to WomanKind each month, with more than 7,000 women having received advocacy services since the program's inception. Four full-time staff members and over 100 volunteers provide free and confidential services 24 hours a day, 7 days a week, mostly funded by the Fairview Hospital and Healthcare Services Corporation, the Fairview Hospitals Auxiliary, and the Fairview Foundation.

Nationally recognized as a model program, WomanKind has brought about change in the medical system's response to victims of domestic violence so that health care professionals treat more than just the presenting physical problem; they also address the underlying causes of the medical or mental health problem.⁴

AWAKE Model

The Advocacy for Women and Kids in Emergencies (AWAKE) program at Children's Hospital in Boston is a model particularly suited to children's hospitals and child protective services, which see women in connection with their children, and not primarily because of their own situations. The project assumes that in at least 75% of child abuse cases, there is also a battered woman, and that it is generally the father or the adult male in the family who is abusing

⁴ Adapted with permission from materials sent to us by WomanKind.

both the mother and the child. By mobilizing police, court, housing, shelter, and welfare advocacy services and other support and referrals on behalf of the mother, the AWAKE staff help her to be safe and prevent her children from being unnecessarily placed in foster care.

Since October of 1986, AWAKE staff have provided advocacy and consultation to over 425 women and more than 500 children. A follow-up survey of 46 women who used the AWAKE services found that 80% had no recurrent violence against either themselves or their children, and that 81% of them had physical custody of their children.

In addition, AWAKE trains and consults with other hospitals, battered women's programs, and child protective service agencies about how to create more innovative programs that will better bridge battered women's and child abuse services in order to keep women and children safe from abuse.

Shelter Outreach Model

The shelter outreach model was the first model used and the one requiring the least medical resources devoted to domestic violence work. Employees or volunteers from the shelter are on call to come to the emergency room when a battered woman is seen, particularly in the evening hours when battered women most often seek medical help.

A less good option has the emergency room staff arranging for the battered woman to be in telephone contact with the shelter for services. Obviously, making personal contact is highly desirable, but the resources of the shelter staff and their lack of proximity to the hospital may make it impossible to have a domestic violence advocate present at the emergency room.

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS STANDARDS

In 1989, even before the AMA published its guidelines, the National Coalition Against Domestic Violence and the Task Force on Health Care Policies of the Philadelphia Coalition on Domestic Violence, along with a number of health care organizations, contacted the Joint Commission on Accreditation of Healthcare Organizations (JCAHO or Joint Commission), the country's largest and oldest health care standard-setting and accrediting body. JCAHO accredits more than 5400 hospitals and 3600 home care mental health, ambulatory care and long term services (Joint Commission, 1992, p.3). They asked that the JCAHO revise its "Emergency Services" standards to require hospital emergency department procedures to discuss how they should respond to assisting battered women, victims of elder abuse, as well as to the victims of rape, sexual molestation and child abuse already addressed.

The JCAHO responded to the request by revising and expanding the Joint Commission's standards for abused victims to specifically include victims of spousal and elderly abuse. These new standards were made effective as of January 1, 1992, revised as of January 1, 1994, and govern both hospital handling of emergency services and ambulatory care services (Joint Commission, 1992, pp.1-3). They appear in both the "Emergency Services" and "Hospital-Sponsored Ambulatory Care Services" chapters of the organization's 1992 ACCREDITATION MANUAL FOR HOSPITALS (*Id.*, at 1). ACCREDITATION MANUAL FOR HOSPITALS 1993 explained how the JCAHO would score the guidelines and that starting in 1994 all health care organizations which JCAHO accredits must have spouse abuse policies in place.⁵

⁵ The latest Accreditation Manual for Hospitals is available from the Joint Commission on Accreditation of Healthcare Organizations, 1 Renaissance Blvd., Overbrook Terrace, IL 60181. The relevant portion of the manual containing the standards and scoring guidelines regarding domestic violence may be ordered from the Family

The JCAHO evaluates a hospital's policies and procedures every three years, but the hospital is responsible for updating them every year (*Id.* at 449). Joint Commission standards for policies and procedures are voluntarily subscribed to for the purpose of being accredited. They are neither laws nor regulations, but are regarded as minimal acceptable standards. They can be cited in court to show that a hospital did or did not provide proper care (Zimmerly & Patterson, 1993, Vol. 6, p.431).

JCAHO standards vary depending on the program's level. The four levels depend on how many hours per day the emergency room is open, who staffs it, and how long it takes a doctor on call to arrive. Level I facilities are always open with a physician experienced in medical care on-duty in the emergency area; have in-house qualified doctors in medicine, surgery, orthopedics, obstetrics/gynecology, pediatrics, and anesthesia, and other specialists available within thirty-minutes; and have in-house capability of managing physical and related emotional problems. Level IV facilities need only be able to determine whether an emergency exists, render life-saving first aid, and make referrals to the nearest facilities (Zimmerly & Patterson, 1993, pp.441-42).

FEW HOSPITALS HAVE DOMESTIC VIOLENCE GUIDELINES

Despite clear intentions that all hospitals would have domestic violence guidelines, it is clear from discussions with health care staff and battered women's programs around the country that many programs still do not have protocols, and many hospitals that do are not regularly using them.

A Family Violence Prevention Fund report released in August of 1993 found that only 18% (59 of 319) of California emergency department policies specifically addressed spouse/partner abuse (Lee et al., 1993, p.4). Furthermore, few of the fifty-nine policies met the JCAHO requirements. Only fifty-eight percent of them addressed notification of authorities, 34% how to conduct a physical exam, 24% the taking of photographs as evidence, 19% the gathering of physical evidence, and 14% what to put in the medical record regarding the physical exam, treatment, referrals, and/or notification of authorities (*Id.* at 5).

Given the inadequacies of these guidelines, local or statewide domestic violence programs may well want to have input into drafting or improving a facility's domestic violence policy and/or procedure.

OBTAINING DOMESTIC VIOLENCE POLICIES

A domestic violence program or the state domestic violence coalition wanting to be sure that a health care facility in its area has a good domestic violence policy or procedure will want to contact the facility to see what it has already done. Given that the Joint Commission standards require health care facilities to make referrals as appropriate to community agencies in cases of domestic violence (Accreditation Manual ES. 4.1.2.9.1 and 4.1.2.9.4), it is expected that facility staff will want to cooperate readily with the domestic violence programs in their community to learn what services they have and how they can best utilize them. This has been the overwhelming experience of state and local domestic violence programs. Furthermore, health care providers are now in a position to seek collaborative means to coordinate with available community services, such as domestic violence shelters.

However, experiences have differed as to which staff in a given facility have been most cooperative with domestic violence programs. As a general rule the emergency room nurses and social workers have been the most eager to cooperate, and the hospital's legal department the least likely to cooperate. Hospital legal departments seldom know anything about clinical practice guidelines. Furthermore, they often fear that outside contacts are made in anticipation of suing the hospital. Hence, hospital legal staff are likely to act defensively or to delay if contacted by an outside group. In contrast, nurses and medical social workers tend to be most concerned with total patient care and may be most likely to make referrals. As a result, they usually readily see the advantages of working cooperatively with domestic violence programs.

Alternatively, approaching the local medical, nursing and public health professional organizations to design a public event, training, conference, or even a fundraiser for the local domestic violence program would be a good way to make contact, with the goal of working together cooperatively on behalf of battered women.

In working with hospital staff, domestic violence program staff should stress the ways that they can cooperate with medical facilities to better coordinate services for battered women and batterers in their communities. They can emphasize that they know how difficult many health care workers find battered women, and that they can take many referrals which will ease the burden of the health care workers. They can offer to help the hospital meet the JCAHO standards on spouse abuse, provide training(s), and help develop policies and procedures on spouse abuse.

If the health care facility refuses to voluntarily provide its guidelines to a domestic violence program, the program may experience some difficulty in obtaining them. As a matter

of law, JCAHO policies and procedures are not available as a right to the public. However, if the health care facility is a federal program (*e.g.*, it is a Veteran's Administration, Public Health Service, or Centers for Disease Control facility), any member of the public can make a Freedom of Information request to the facility for the policy or protocol. Some states and possibly some counties or cities have their own state or local Freedom of Information Act.

All Freedom of Information Act requests are slow, and the requestor can be charged for the information. Hence, other avenues for obtaining existing copies are usually far more desirable. Having a sympathetic emergency room worker or hospital staff from another hospital call to discuss their common problem of how to respond in domestic violence cases may well produce the desired guidelines.

Another approach might be for the domestic violence program staff to approach a sympathetic board member of the facility, expressing the same concerns and offering the same assistance as was suggested for contacting emergency room nurses and/or social workers. Any responsible board member should be concerned with the hospital's compliance with JCAHO requirements, its health care, and its reputation in the community. Many board members are already tied into other community services and will want to have a good relationship with domestic violence programs in their community.

Finally, filing a complaint through the patient grievance procedure might secure the desired protocol and procedure. The complaint would allege that one or more victims of domestic violence was inappropriately treated either because there were no policies and/or procedures, or the policies and/or procedures were inadequate, or not followed, or were inadequately followed. In addition, the person filing the complaint should request copies of any

policies and procedures for dealing with domestic violence. Since this approach will be seen as adversarial, it is not wise to use it unless the previously suggested approaches have failed.

**PREFERRED ELEMENTS OF A HEALTH CARE PROTOCOL AND PROCEDURE
USED TO TREAT VICTIMS OF DOMESTIC VIOLENCE AND/OR SPOUSAL ABUSE
IN HOSPITALS OR HEALTH CARE ORGANIZATIONS⁶**

Because excellent protocols and policies exist (see National Center on Women and Family Law, Item No. 54, Medical Domestic Violence Protocols and Standards)⁷, health care facilities, particularly those cooperating with domestic violence programs, should be able to implement protocols and policies which fully comply with the Joint Commission requirements.

Domestic violence advocates working with hospital staff will want a comprehensive domestic violence protocol and procedure, probably including the following:

1. Provisions for separating all females from their partners until battering is ruled out.
2. Provisions for interviewing any woman in an emergency setting alone, including provisions for separating or removing an abuser.
3. Complete physical examination once a suspicion of battering is established.
4. Assessment of potential suicide/homicide risk of the suspected battered woman.
5. Provisions for the identification and documentation of who caused the injuries.
6. Women should be reminded of right to access of their medical records.
7. Information/help on leaving battering homes.
8. Referrals for counseling, where indicated.

⁶ Special thanks to Jacquelyn Campbell for suggesting many items of the Preferred Elements of a Medical Protocol and Procedure.

⁷ See Summary of Item No. 54, Appendix 3, beginning on page A-3.

9. Explanations of the particular laws in the state governing battered women.
10. Definition of abuse or battering that include physical, sexual, financial, and emotional abuse.
11. Discussion of the impact of domestic violence on battered women, dispelling myths about the problem and explaining why a patient might be reluctant to disclose abuse.
12. Criteria for the identification of battered women, including both physical and psychological symptoms.
13. Discussion of interviewing techniques.
14. Crucial questions to ask during history taking.
15. Discharge planning.
16. Hospital provisions for collection, retention, and safeguarding of specimens, photographs and other evidentiary material released by the patient.
17. Guidelines regarding legally required notification of, and/or release of information to, the proper authorities.
18. Documentation in medical records -- including the use of body map, suspected cause of injury, and documentation of examination, treatment given, referrals made to other care providers and community agencies, and any reporting required to proper authorities.
19. Notification of the availability of domestic violence programs and other services, such as social service and counseling agencies, legal services, criminal justice system and childrens' services.
20. Provisions for training in hospitals in identification, treatment, and referral of battered women.
21. Discussion of patient consent and confidentiality.
22. Presentation of statistics on domestic violence and a discussion of dynamics of domestic violence.
23. Facts about different forms of domestic violence.
24. Examination of previous medical history of suspected victim of spousal abuse or of domestic violence, including previous emergency visits for trauma or related illness.

25. Provisions for training hospital police or security to handle domestic violence security problems.
26. Provisions for hospital police or security coverage on all shifts, detailed so that they police any area where women are interviewed and treated.
27. Discussion of the typical batterer's tactics and danger.
28. Discussion of batterer treatment, including standards for batterer intervention programs; and the dangers of couples counseling, marital counseling, and mediation.
29. Discussion of how domestic violence affects children in the household.
30. Discussion of how to support the victim in keeping custody of any minor children involved.

The following elements, although not ordinarily a part of a protocol, will be helpful for responding to inappropriate referrals:

31. Sample letter to send a court or outside agency making an inappropriate referral to explain why the referral is inappropriate and against hospital protocol and procedures.⁸
32. Sample letter to explain why someone referred to a batterer treatment or education program was wrongfully referred, because the person was actually a victim of domestic violence.⁹

The few domestic violence protocols that now exist are often not comprehensive. For example, existing protocols seldom deal with the impact of domestic violence on children. The Family Violence Prevention Project's survey of California protocols found that only 14% fully or adequately addressed definitions of domestic violence, the dynamics of domestic violence, how to identify domestic violence related presenting problems, and appropriate interventions (Lee et al., 1993, p.5). While what is included in the protocol is important, it is also important that a health care facility's policy or procedure should not include any inappropriate

⁸ See Appendix 1, page A-1.

⁹ See Appendix 2, page A-2.

stereotyping, referrals, interventions or treatments. If, for example, hospital staff are referring battered women and their abusers to couples counseling, an explicit statement may be needed stating that such referrals are not appropriate. Similarly, treating only the abuser's (or victim's) drinking problem without addressing the domestic violence problem might further endanger the victim and the children (Zubretsky & Digirolamo, 1994, p.4).

CONFIDENTIALITY CONSIDERATIONS

A battered woman will not feel safe talking in front of her abuser. She may also be reluctant or unwilling to talk about her situation if any family members or even friends are present. Furthermore, by allowing any unnecessary person present (except possibly a baby too young to comprehend anything), she will lose the benefit of any confidentiality privilege.

As a result, any domestic violence policy and procedure should include provisions for interviewing the woman out of the hearing of anyone else, for having someone not known to either her or her abuser translate if a translator is necessary, for having a play area or someone who can temporarily take care of her children while she is interviewed, and for preventing the release of any information, particularly to her abuser. Abusers are often highly imaginative in impersonating family members, healthcare personnel, or criminal justice system authorities in an attempt to obtain information about their victim.

Like any other patient, a battered woman has the right to obtain and use her medical records. These records may later be needed in a child custody case or if the woman decides to seek a protection order, pursue criminal charges or a tort suit against her abuser, or sue the police.¹⁰

¹⁰ See Joan Zorza, "Suing the Police After *DeShaney*," National Center on Women and Family Law, 1994.

Domestic violence protocols and procedures should include provisions for confidentiality and for victims to have access to their medical records. In addition, they should include provisions for the training and detailing of hospital security or police so that any area where women are interviewed will be safe for the women interviewed and their children, with provisions for removing or arresting the abuser, where indicated. Batterers can range from bullying their way into treatment areas, trauma rooms and interviewing officers to acting contrite and remorseful in the hope of engendering the sympathy of treatment staff to learn information about the victim.¹¹

HOW TO INFLUENCE THE CONTENT OF THE GUIDELINES

If something which should be discussed is not included in the policy or protocol, suggest it to someone likely to be cooperative. Likewise, if something inappropriate is in it, try a cooperative approach to have it removed or acceptably modified. Many good models exist for medical policies (*see* discussion Section "Preferred Elements of a Health Care Protocol and Procedure Used to Treat Victims of Domestic Violence and/or Spousal Abuse in Hospitals or Health Care Organizations" beginning on page 15, and Appendix 4, beginning on page A-6). Most hospital staff are genuinely concerned and will want to cooperate.

However, if friendlier, nonadversarial approaches fail to work, a patient could file a grievance against the hospital or facility to raise the problem.

Alternately, if an accredited hospital does not (1) routinely interview each female patient alone and out of hearing of anyone accompanying her; (2) have any written domestic violence

¹¹ See WomanKind, 1994 Protocol Provisions on Privacy and Confidentiality, available from WomanKind, Inc., Fairview Southdale Hospital, 6401 France Avenue S., Minneapolis, MN 55435.

policy; (3) mention domestic violence on its intake forms; (4) photograph domestic violence victim's injuries; (5) provide referrals to domestic violence victims; or (6) regularly provide domestic violence training to its emergency room staff, an aggrieved patient may send a complaint to:

Carol Engle, Associate Director
Department of Governmental Relations
Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

Finally, an aggrieved patient could bring a medical malpractice complaint to the state's administrative agency or in the courts if the matter resulted in a patient's injury. Obviously, if the domestic violence program were seen to be involved in a malpractice complaint, the claim would not facilitate a good ongoing relationship between the hospital and the domestic violence coalition or program. However, any court or administrative malpractice challenge would probably come from the woman herself, or her estate, and, thus, would not necessarily tarnish the relationship of the hospital and domestic violence program.

ROLE OF DOMESTIC VIOLENCE PROGRAMS

Domestic violence programs have much to offer health care facilities. A domestic violence program can offer training in domestic violence because of its longstanding experience and expertise on the issue. In addition, a domestic violence program can be helpful as a referral resource, both for accepting referrals from the medical facility and as a provider of vital information about the usefulness of other programs in the community. The domestic violence program can share its knowledge and expertise about how cooperative are the neighboring

police, prosecutors and courts, and what works best in the different neighboring cities and towns. The domestic violence program can also share what it knows about other resources in the community, such as the quality of those resources or whether they have long waiting lists. The medical facility probably will especially want to know what batterer education/treatment programs exist and which ones work best.

By working together, domestic violence and health care programs can best help each other and the victims of domestic violence whom they serve. The best programs to date have combined domestic violence or shelter advocates with health care professionals, working together on all aspects of the program, including trainings and evaluations.

REFERENCES

- Lee H. Bowker & Lorie Maurer (1987). *The Medical Treatment of Battered Wives*. Women and Health, 12(1).
- Jacquelyn Campbell, *Nurses Have Been Saying It*. NCADV VOICE 5-7 (Winter 1994).
- Jeffrey L. Edleson & Richard M. Tolman, INTERVENTION FOR MEN WHO BATTER: AN ECOLOGICAL APPROACH (Newbury Park, CA: Sage 1992).
- Anne Flitcraft, *The AMA Guidelines One Year Later*. NCADV VOICE 3-5 (Winter 1994).
- Anne Flitcraft, Susan M. Hadley, Marybeth K. Kendricks-Matthews, Susan V. McLeer, & Carol Warshaw, *Diagnostic and Treatment Guidelines on Domestic Violence*. AMERICAN MEDICAL ASSOCIATION (March 1992)[hereinafter Flitcraft, et al., 1992].
- Anne Flitcraft & Evan Stark (1991). *Spouse Abuse in Violence in America: A Public Health Approach*, Mary Ann Fenley and Mark L. Rosenberg, Ed., Oxford University Press.
- C. Hames, H. Holtz, & M. Safran, Ed. (1989). *About Domestic Violence in Unites States and Canadian Medical School, 1987-1988*. Morbidity and Mortality Weekly Report 38 (17), 1989.
- Michele Harway & Marsali Hansen. *Therapists' Recognition of Wife Battering: Some Empirical Evidence*. Family Violence Bulletin (6/3) 16-18 (Fall 1990).
- Joint Commission on Accreditation of Health Care Organizations (JCAHO) Standards for Hospitals, 1991. March 27, 1991.
- Journal of the American Medical Association, June 17, 1992.
- Demie Kurz & Evan Stark. *Not-So-Benign Neglect: The Medical Response to Battering in Feminist Perspectives on Wife Abuse*, Michelle Bograd and Kersti Yllo, Eds., Sage Publications (1988) 249-266.
- Debbie Lee, Patrick Letellier, Elizabeth McLonglin & Patricia Salber, *California Hospital Emergency Departments Response to Domestic Violence - Survey Report*. FAMILY VIOLENCE PREVENTION FUND, San Francisco (August 1993).
- C.U. Lindquist, C.F. Telch & J. Taylor, Evaluation of a Conjugal Violence Treatment Program: A Pilot Study, BEHAVIORAL COUNSELING AND COMMUNITY INTERVENTION 3, 76-90 [see p.A8 for a summary].

March of Dimes, Request for Proposal from Andronike Tsamas for Campaign for Healthier Babies, 6/23/93, p.3 (on file with National Center on Women and Family Law).

Janet Mickish, Kathy A. Gaines & Deborah Haack, DOMESTIC VIOLENCE: A GUIDE FOR HEALTH CARE PROVIDERS, 4th Ed., Colorado Department of Health and Colorado Domestic Violence Coalition (1992).

National Center on Women and Family Law, Item No. 54 - Medical Domestic Violence Protocols and Standards (July 1992).

National Center on Women and Family Law, Item No. 62 - Couples Counseling and Couples Therapy Endanger Battered Women (October 1993).

Stacey Plichta (Fall 1992). *The Effects of Woman Abuse on Health Care Utilization and Health Status: A Literature Review*, Jacobs Institute of Women's Health, Vol. 2, No. 3, Fall 1992.

Susan Schechter (1987). *Guidelines for Mental Health Practitioners in Domestic Violence Cases*. National Coalition Against Domestic Violence.

Susan Schechter with Lisa Klee Mihaly (November 1992). *Ending Violence Against Men and Women in Massachusetts Families: Critical Steps for the Next Five Years*. (Boston: Massachusetts Coalition of Battered Women Service Groups).

Seattle Domestic Violence Intervention (1989). *Domestic Violence: A Community Crisis Waiting for an Effective Response*.

Evan Stark & Anne Flitcraft. *Violence Among Intimates: An Epidemiological Review*, 293-317 in Handbook of Family Violence, Vincent B. Van Hasselt, Randall L. Morrison, Alan S. Bellack & Michel Herson, Eds. (New York: Plenum Press, 1988).

Evan Stark, Anne Flitcraft & William Frazier. *Medicine and Patriarchal Violence: The Social Construction of a "Private" Event*. 9 INTERNATIONAL J. HEALTH SERVICES 461-493 (1979).

James G. Zimmerly & Richard M. Patterson, LAWYERS' ENCYCLOPEDIA OF PERSONAL INJURIES AND ALLIED SPECIALTIES, 3d Ed. (1993, 1991).

Theresa M. Zubretsky & Karla M. Digirolamo. *Adult Domestic Violence: The Alcohol Connection*, 4 VIOLENCE UPDATE 1-8 (March 1994).

APPENDICES

APPENDIX 1

Sample Letter in Response to Inappropriate Conjoint
Counseling Referral

Probation Office
Court House

Re: Referral of David Smith and Mary Smith to Couples Counseling

Dear Sir/Madam:

On (date) your office referred the above-named parties to (conjoint/couples/family/marital) counseling at our facility. However, this is to notify you that we are unable to accept the referral. Mr. Smith has a history of being abusive against Mrs. Smith. Any counseling of the parties together is contraindicated because of the risk of further serious harm to Mrs. Smith (and any children in their household).

In order for our facility to be accredited it must meet the standards of the Joint Commission on Accreditation of Healthcare Organizations. Those standards require us to have a domestic violence protocol and policy. Consistent with the American Medical Association's Diagnostic and Treatment Guidelines on Domestic Violence, our policy prohibits referrals of couples where there has been domestic violence into any kind of counseling together, at least until after all violence and emotional abusiveness have ended for six months. Furthermore, according to our policy it is contraindicated to send an abuser into any program where he is not required to accept full responsibility for his abusiveness. Sending both parties together into counseling gives the wrong message that both parties share in the blame for the abusive behavior. Such a message encourages the abuser to deny full responsibility for his abusive behavior, while encouraging the victim to focus on what she can do to change her behavior, instead of how she can keep herself (and any children) safe.

I enclose literature about another program we have for educating and treating batterers which we believe would be appropriate for Mr. Smith, if you chose to refer him to it.

Feel free to contact me if I can be of any further assistance.

Sincerely yours,

/s/

Name

Title

cc: David Smith
Mary Smith

APPENDIX 2

Sample Letter in Response to Inappropriate Referral of
Victim into Batterer Treatment

Probation Office
Court House

Re: Referral of Jennifer Jones into Batterer Education Program

Dear Sir/Madam:

On (date) your office referred Ms. Jones into our batterer education and treatment program after her arrest as a domestic violence perpetrator.

We have evaluated Ms. Jones and have found that she is in actuality the real victim of domestic violence which (name of abuser) has been inflicting against her for the past (# of months/years). We have sent Ms. Jones to a program for victims of domestic violence who either were attempting to act in self-defense or were wrongfully accused. In this program she has been instructed on the dynamics of domestic violence, how it adversely affects any children in the household, and what her options are for safety (including leaving her abuser and/or obtaining a court order for protection). Since Ms. Jones has successfully completed this program for victims accused of battering, we are informing you that we have terminated her from our program.

If we can be of any further assistance please feel free to contact us.

Sincerely yours,
/s/
Name
Title

cc: Ms. Jennifer Jones

APPENDIX 3

MATERIALS AVAILABLE FROM THE NATIONAL CENTER ON WOMEN AND FAMILY LAW WITH RESPECT TO MEDICAL DOMESTIC VIOLENCE PROTOCOLS AND STANDARDS:

MEDICAL STANDARDS AND PROTOCOLS

Hospital Standards

1. New Standards Approved by the Joint Commission on Accreditation of Healthcare Organizations on Domestic Violence. (8 pp., \$2.00)

AMA Guidelines

1. Diagnostic and Treatment Guidelines on Domestic Violence of the American Medical Association. (10 pp., \$2.00)

Medical Protocols

1. Identifying and Treating Adult Victims of Domestic Violence, N.Y.S. Department of Health in Collaboration with New York State Office for the Prevention of Domestic Violence (January 1990). (25 pp., \$5.00; note that blank pages are not reproduced).

2. Colorado Department of Health and Colorado Domestic Violence Coalition, *Domestic Violence: A Guide for Health Care Providers*, Section V - "Protocol: Development, Implementation, and Maintenance" (8 pp., \$2.00; note that blank pages are not reproduced). Also note that because Colorado law requires physicians to report all criminal acts, including domestic violence, its protocol has to include this requirement.

3. "Medical Facilities," Model Ohio Protocol for Responding to Domestic Violence, Ohio Department of Human Services in Cooperation with the Legal Aid Society of Cincinnati, October 1992 (16 pp., \$3.50).

ARTICLES

1. Articles from JAMA (Journal of American Medical Association), Vol. 266, No. 9, September 4, 1991 (4 pp.) (includes Teri Randall, *Hospital-Wide Program Identifies Battered Woman; Offers Assistance*, a description of the WomanKind model for treating battered women); Vol. 267, No. 23, June 17, 1992 (20 pp., \$5.00).

2. *Doctors Are Advised to Screen Women for Abuse*, THE NEW YORK TIMES, 6/17/92, page A26 (1 p., \$.50).

3. *Hospital Standards Approved for Victims of Adult Domestic Violence and Elder Abuse*, THE WOMEN'S ADVOCATE, NCOWFL, May 1991, Vol. 12, No. 3. (1 p., \$.50)
4. Family Violence (position paper), The National Health, September 1991, American Public Health Association. (3 pp., \$.75)
5. Nancy Worcester, *The Unique Role Health Workers Can Play in Recognizing and Responding to Battered Women*, THE NETWORK NEWS, National Women's Health Network, March/April 1992. (4 pp., \$1.00)
6. L. Kevin Hamberger & Daniel G. Saunders, *Battered Women in Nonemergency Medical Settings: Incidence, Prevalence, Physician Interventions*, paper presented to the American Psychological Association, San Francisco, CA on 8/18/91. (8 pp., \$2.00)
7. Articles from FOR BETTER TIMES, a quarterly publication of the Illinois Coalition Against Domestic Violence, Spring 1992, Vol. 10, No. 1. (9 pp., \$2.00)
8. Susan M. Hadley, *Working With Battered Women in the Emergency Department: A Model Program*, 18 JOURNAL OF EMERGENCY NURSING 1, 18 (6 pp., \$1.50).

All the items listed above are available for a total price of \$16.00 from the National Center on Women and Family Law, 799 Broadway, Suite 402, New York, NY 10003.

ADDITIONAL RESOURCES AVAILABLE FROM OTHER SOURCES

1. Susan Schechter, *Guidelines for Mental Health Practitioners in Domestic Violence Cases*, available from National Coalition Against Domestic Violence, P.O. Box 18749, Denver, CO 80218-0749. (1987)(24 pp.), \$9.50 for NCADV members, \$12.00 for others.
2. Chapter 13: *A Protocol for Family Violence, Psychiatric Response to Family Violence: Identifying and Confronting Neglected Danger*, Edward W. Gondolf. (MacMillan Publishing Co., New York), \$34.95
3. DOMESTIC VIOLENCE: A GUIDE FOR HEALTH CARE PROFESSIONALS, State of New Jersey: Department of Community Affairs, Division on Women, 101 South Broad Street, CN801, Trenton, NJ 08625-0801 (March 1990). Free to New Jersey advocates, \$10.00 for others. Videos for training are also available.
4. Colorado Department of Health and Colorado Domestic Violence Coalition, DOMESTIC VIOLENCE: A GUIDE FOR HEALTH CARE PROVIDERS, 4th Edition (1992), Colorado Coalition Against Domestic Violence, P.O. Box 18902, Denver, CO 80218, \$45. "Protocol: Development, Implementation and Maintenance" (8 pp.). Note that because Colorado law requires physicians to report all criminal acts, including domestic violence, its protocol has to

include this requirement.

5. Ohio Physicians' Domestic Violence Prevention Project. Domestic Violence Handbook and Supplies, The Ohio State Medical Association, 1500 Lake Shore Drive, Columbus, OH 43204-3824.

6. WomanKind Protocol. Contact Susan M. Hadley, WomanKind, Inc., Fairview Southdale Hospital, 6401 France Avenue S., Minneapolis, MN 55435.

7. Massachusetts Department of Public Health, Identifying and Treating Battered Adult and Adolescent Women and Their Children, 1992.

8. NCADV VOICE, Winter 1994. Special Edition: Domestic Violence as a Health Issue, \$2.50 from NCADV, P.O. Box 34103, Washington, DC 20043-4103.

9. Jacquelyn C. Campbell & Janice Humphreys, Nursing Care of Survivors of Domestic Violence (St. Louis: Mosby 1993).

10. Jacquelyn C. Campbell, Danger Assessment (Risk Factors for Homicide in Battering Relationships). Contact Jacquelyn C. Campbell, Johns Hopkins University School of Nursing, 1830 E. Monument, Baltimore, MD 21205, (410) 550-5481 FAX.

11. Nursing Network on Violence Against Women International. Contact Daniel Sheridan, 14980 S.W. 103rd Avenue, Tigard, OR 97224, (503) 494-7207, (503) 494-4357 FAX. Ask for literature list, network list, help with trainings.

12. Daniel J. Sheridan & Wendy K. Taylor, Developing Hospital-Based Domestic Violence Programs, Protocols, Policies and Procedures. Request from Daniel J. Sheridan, *id.*

13. Abuse Screen (4 questions designed to be used in health care settings to detect abuse). From Barbara Parker, University of Virginia School of Nursing. (804) 982-1809 FAX.

14. American Medical Association/American Bar Association Guidelines from Martha Witwer, AMA, Department of Mental Health, 8th Floor, 515 North State Street, Chicago, IL 60610, (312) 464-5913.

15. Family Violence Prevention Fund's health project is developing many materials. Contact them at 383 Rhode Island Street, Suite 304, San Francisco, CA 94103-5133, 1-800-313-1310.

APPENDIX 4

Item No. 62

Couples Counseling and Couples Therapy Endanger Battered Women¹

This packet discusses the danger that a battered woman experiences in any kind of counseling or therapy with her abuser. Some other names for these kinds of therapy are conjoint therapy, family therapy, marriage counseling and joint therapy.

In this packet, the page(s) of a citation or quotation or reference will appear in bold between two parentheses, *e.g.*: (p.79). At the end of this packet, in section IV, are some of the other articles referred to in the quotations used in the packet.

I FEW THERAPISTS ARE TRAINED IN OR HAVE ADEQUATE KNOWLEDGE OF DOMESTIC VIOLENCE

1. Michele Harway & Marsali Hansen, *Therapists' Recognition of Wife Battering: Some Empirical Evidence*, FAMILY VIOLENCE BULLETIN (6,3) 16-18 (1990) reported on 362 therapist members of the American Association of Marriage and Family Therapy who responded to a mail questionnaire asking them to analyze one of two actual cases involving severe woman battering.

(a) Forty-one percent of therapists completely missed any of the obvious evidence of domestic violence.

(b) Not one therapist identified that lethality was a concern, although this was the eventual outcome to the woman in one of the cases.

(c) Even those therapists who identified the conflict badly minimized its severity: 91% considered it mild or moderate. Only 23% identified it as violence or battering, with the others characterizing it as "an abusive relationship (16%), conflict (7%), anger (5%), power struggle (4%), lack of control (1%), or other (3%).

(d) Fully 55% of therapists would not intervene. Only 1-% mentioned obtaining protection for the wife (*e.g.*, safety plan, shelter, or helping her get a restraining order). Twelve percent would report the abuse (but did not clarify what abuse, spouse or child, and to whom they would report it). By contrast 14% would

¹ Many thanks to Sally Otos, a law student intern, who did much of the research that formed the basis for this packet.

work on the couple's communication style.

(e) Psychologists were the least likely of all practitioners (among marriage and family therapists, clinical social workers, psychiatrists and miscellaneous others) to either address the conflict in their conceptualization of the case or describe the family conflict as violence.

(f) Male and female therapist did not differ in how they would address the conflict, how serious it was, or how they would intervene.

(g) Not only do the authors characterize the 41% who failed to identify violence as committing malpractice, but they warn that most of the others who minimized the seriousness or neglected to protect the wife were giving improper treatment.

2. Michele Harway, *Training Issues in Working with Violent Families*, FAMILY VIOLENCE & SEXUAL ASSAULT BULLETIN (8,2), 18-20 (1992). Following up on the prior study, therapists were told that in an actual case the husband had murdered his wife. While few therapists blamed the victim, only 19% attributed the problems to the husband. Only 16% of the therapists assigned DSM III-R diagnosis to the husband (usually 312.34, intermittent explosive disorder). Most therapists "attributed responsibility to a systematic problem of the couple" or "felt that they had insufficient information even after they were told that Carol had been murdered." Over half of the therapists still failed to invoke any type of crisis intervention on behalf of protecting the wife; instead 27% wanted to further assess the violence, 11% would have intervened through couples' communication exercises or the venting of feelings and a few actually suggested that the wife, Carol, tone down her behavior.

Noting that over half of therapists failed to focus on ensuring the safety of the victim, the author states: "These findings suggest that some psychotherapists' interventions have the potential of being dangerous to the client." She also recommends training for all new and practicing therapists, including supervisors (including psychologist, marriage and family therapist, mediators, psychiatric nurses, social workers, and public health workers) in identification of violence, its prevalence in families, recognition of violence in a particular client family, recognition of its seriousness (with a presumption that it is serious), understanding and properly attributing the psychological basis for the violence and knowledge of appropriate interventions in cases of violence.

II EXPERIMENTAL LITERATURE SHOWS THAT CONJOINT THERAPY DOES NOT STOP AND MAY EVEN INCREASE VIOLENCE IN ABUSIVE RELATIONSHIPS

1. Jeffrey L. Edleson & Richard M. Tolman, *INTERVENTION FOR MEN WHO BATTER: AN ECOLOGICAL APPROACH* (Newbury Park, CA: Sage Publications 1992) note that "[e]xisting studies of couples intervention have seldom stated the sources of their outcome data. Differences between the level of violence reported by men and women in the

same relationship are dramatic and well documented in numerous studies of violence incident reports offered by couple (see Edleson & Brygger, 1986; Jouriles & O'Leary, 1985; Szinovacz, 1983). . . .[I]f the violent man is the sole reporter of violence at follow-up, the success of an intervention may be greatly inflated." (pp. 104-05). Edleson and Tolman note on pages 103-105 that there are only three evaluation of conjoint couples counseling:

(a) C.U. Lindquist, C.F. Telch & J. Taylor (1985). *Evaluation of a Conjugal Violence Treatment Program: A Pilot Study*, BEHAVIORAL COUNSELING AND COMMUNITY INTERVENTION, 3, 76-90, reported 6-week and 6-month follow-ups for couples treated with conjoint therapy for the man's violence. Six weeks after the program ended 50% of the couples treated had experienced at least one incident of violence, and 100% of the couples treated had experienced at least one incident of violence, by six months after the program had ended. They did not include any comparison data for control couples.

(b) J. Harris (1986). *Counseling Violent Couples Using Walker's model*. Psychotherapy 23, 613-621. Based on Lenore Walker's 1979 proposed model for couples counseling, in which couples begin with several individual counseling sessions and then continue with both individual and conjoint sessions for the rest of the treatment aimed at ending the man's violence and appropriately placing responsibility for the violence on him. Seventy-three percent of the 30 couples that she contacted from 2 months to 3 years after treatment were "successful," a term which was not defined.

(c) J.W. Taylor (1984). *Structured Conjoint Therapy for Spouse Abuse Cases*. SOCIAL CASEWORK 65, 11-18, like Harris, used a primarily cognitive-behavioral approach to treat couples where the man was violent. In the six months following treatment he reported that 65% of the 50 couples that the treated reported that there had been no new violence, but he does not state how this data was collected or who reported it.

2. A fourth study published since that time purports to evaluate conjoint couples counseling. Elizabeth A. Sirles, Eve Lipchik & Kate Kowalski (1993). *A Consumer's Perspective on Domestic Violence Interventions*, JOURNAL OF FAMILY VIOLENCE (8,3) 267-276, attempted to evaluate forty couples referred to couples counseling in Milwaukee after the husbands had been arrested for beating their wives. Of the forty couples, only 42 individuals participated in the study (7 batterers and 5 victims who participated without their partners as well as 15 couples). Eighty percent of the subjects were ordered into the family therapy by the prosecutor. Success was measured solely in terms of claimed satisfaction and whether the couple remained together, with no questioning or follow-up to see whether the violence diminished. Although 54% of the men and 84% of the victims felt the experience was positive, 23% of the men and 11% of the victims felt the experience was negative. After the therapy, 86% of the subjects were still together and planned to remain together. The therapy focused on what problems led to the violence (money, alcohol, drugs, jealousy, arguments about children,

etc.).

III ARTICLES/BOOKS WHICH WARN OF THE DANGERS TO BATTERED WOMEN OF CONJOINT THERAPY

1. The American Medical Association has promulgated a model protocol, **DIAGNOSIS AND TREATMENT GUIDELINES ON DOMESTIC VIOLENCE** (Chicago, IL, AMA 1992), which states:

"Couples' counseling or family intervention is generally contraindicated in the presence of domestic violence. Attempts to implement family therapy in the presence of ongoing violence may increase the risk of serious harm. The first concern must be for the safety of the woman and her children." (emphasis in original) (p.12)

2. Susan Schechter with Lisa Klee Mihaly, **ENDING VIOLENCE AGAINST WOMEN AND CHILDREN IN MASSACHUSETTS FAMILIES: CRITICAL STEPS FOR THE NEXT FIVE YEARS** (Boston: Massachusetts Coalition for Battered Women Service Groups, November 1992) discussing treatment programs for men who batter, notes "domestic violence perpetrators in the Commonwealth are still rarely held accountable for their behavior. Frequently -- and dangerously -- they are referred for couples counseling or mediation to deal with 'marital conflicts'." (p.20)

The "perfectly reasonable idea of family preservation is unfortunately interpreted in perfectly absurd ways in some domestic violence cases. The idea that children should be kept at home whenever possible is misinterpreted in domestic violence cases as a mandate to keep mother, abusive father and children together. As a result, abused women and their violent husbands are (p.21) still inappropriately referred to counseling or mediation to 'work out their problems for the sake of the children'." (p.22)

After discussing the overwhelmingly inadequate response by health care providers to battered women, which seldom identifies the cause of their injuries, the authors state:

"Worse, some women who seek treatment for injuries caused by beatings receive no information about resources at all; they are simply sent home to be battered again. Still other women are offered inappropriate or dangerous interventions, like marital counseling." (p.41)

"Some judges believe so strongly that it is their mandate to keep families together that, like some child protective workers, they minimize and deny the abuse and its dangers; they inappropriately refer domestic violence perpetrators and their victims to couples counseling and mediation; and they refuse to punish offenders." (p.59)

"RECOMMENDATION 9: The Department [of Social Services, the state's child protective service agency] should adopt a policy that marital and family counseling in domestic violence cases is dangerous and inappropriate." (p.33)

"RECOMMENDATION 19: Every court should declare, as a matter of policy, that domestic violence victims and their assailants should not be referred for family or couples counseling or mediation by any office or clinic of the Court. (p.65) This mandate should prohibit formal and informal mediation over issues like visitation, custody and child support. Family service officers should no longer be allowed to coerce victims with statements like, 'It won't look good to the judge if you refuse to cooperate with me or compromise with your husband.' Forcing victims to negotiate with their assailants puts them in a dangerous -- and inherently unequal -- position, and the courts should stop this practice immediately." (p.66)

The authors continue by warning that because of the batterers danger to the children "the Court should be extremely reluctant to place children in the custody of their mothers batterer." (p.66) Later they even warn:

"RECOMMENDATION 21: The Court needs to carefully screen visitation supervisors who are members of the alleged perpetrator's family.

"Some relatives side blindly with the perpetrator. Still others, frightened by the perpetrator, give in to his demands for unsupervised contact and as a result, fail to protect children in their care." (p.66)

3. Ann Jones & Susan Schechter, *WHEN LOVE GOES WRONG* (New York: Harper Collins Publishers 1992) pages 97, 101-104, 312-313. Couples counseling does not work in abusive relationships, because the controlling man "cares much more for himself than for his partner. He refuses to own up to his own behavior, much less admit there might be something wrong with it. And he wants to continue to get his own way." (p.101) Neither the woman (nor the therapist) may recognize that the problem in the relationship is his controlling behavior (p.101). The therapist will likely concentrate on improving the couple's interaction (p.101), which means she will accommodate him even more while he will be reassured that she is largely to blame. He not only gets his way, plus more attention and compliance, leaving her more discouraged and facing more violence (p.102). Clients must feel safe to tell the truth (p.104). "[T]he controlling partner lies, conning both the therapist and his wife, and then takes it out on her later" (p.104). Or he may drop out of counseling or turn the counseling against her (p.102). "In cases where the controller uses physical force among his tactics, couples counseling can be very dangerous." (p.102)

4. David Adams, *Treatment Models of Men Who Batter: A Profeminist Analysis*, pp.

176-99 in Kersti Yllo & Michele Bograd, eds., *FEMINIST PERSPECTIVES ON WIFE ABUSE* (Newbury Park, CA: Sage Publications 1988). Adams criticizes both couples counseling and group counseling where violent couples are counselled together.

"By assigning the wife the task of helping her husband to bring his violence under control, the therapist is giving a mixed message to both partners about how much 'sole responsibility' the husband should really take for his violence, and whether he should continue to expect certain changes on her part before he makes a commitment to nonviolence.

"Not only do interactive approaches blur the distinctions between violent and nonviolent behavior, but they also give a tacit message that battering is an understandable, though unfortunate, response to behavior on the victim's part that the batterer deems "controlling" or "provocative." . . . Dobash and Dobash (1983, p.59) call attention to the sexist assumptions that underlie the myth of provocation:

The notion of provocation is insidious because what is really being said is that the woman has no real right to negotiate with her husband about issues such as how the money is spend, the time he spends away from home, the amount of assistance he might give with household tasks, or (p.186) about her freedom to go to work, engage in her own interests if such negotiations irritate or offend him.

". . . When the woman's "precipitating" behavior becomes the object of focus and when men's definitions of their wives' actions go unquestioned, therapists implicitly reinforce men's attempts to divert attention away from their own choices. To focus on what the woman can do to prevent her husband's anger not only compromises the woman's right to express her own anger, but denies the man's basic responsibility to express his feelings and reactions in a nonviolent manner.

"Besides clouding the issue of who is responsible for the violence, couples counselling places the battered women in an impossible bind. Though she is expected to be open about her feelings, air her grievances, and report her husband's violence, to do any of these things places her in grave danger of continued violence. Many battered women report that past family therapy sessions were followed by violent episodes. The threat of continued violence leads battered women to communicate their feelings and concerns in an indirect manner, which is often misinterpreted by couples counselors as noncompliance (Ganley, 1981).

"Interaction therapists violate their own logic by being only selectively attentive to violence as an overriding influence in the marital interaction. Poor communication is seen by interaction therapists as a contributing factor, rather than as an inevitable effect of violence. Most therapeutic interventions are accordingly directed at improving the couple's communication. Critics of this approach do not deny that there is a communication problem, but they do deny that it can be rectified so long as the violence, or the threat of violence, persists (Ganley, 1981; Schechter, 1982; Walker, 1984). But violence creates fear and distrust in both partners, which in turn determines how each will respond and communicate with the other. For the woman, fear of his violence prevents her communicating her own wishes and feelings in a (p.187) direct or consistent manner. For the man, violence gains compliance but also perpetuates his fears of her independence and anger about her noncompliance, which reinforces his attempts to control her. The woman cannot stop being afraid so long as the threat of violence is present. So long as this is so, neither can trust or openly communicate with each other." (p.188)

5. Richard A. Stordeur & Richard Stille, **ENDING MEN'S VIOLENCE AGAINST THEIR PARTNERS** (Newbury Park, CA: Sage Publications 1989). Excellent summary of the problems with joint therapy. Three short sections refer to joint therapy: pp.25-26:

"From the family systems perspective, violence is a relationship issue, with violence being one symptom of a disturbed or pathological relationship (citations omitted). One of the basic premises of systems theory is that all parts of the system contribute to the maintenance of homeostasis, defined as the tendency of a system to maintain a dynamic equilibrium and to undertake operations to restore that equilibrium whenever it is threatened (citation omitted). The family system works continually to maintain his homeostasis, even when it is achieved through dysfunction. Thus all members of the family participate in the system and carry the responsibility for family dysfunction. In this context, battering is no longer simply the responsibility of the batterer, but a behavior that is maintained by the actions of all family or system members.

"Family systems theory suggests that battering is the result of repetitive interactions between family members characterized by certain relationship structures or dynamics, and that it serves a functional role in maintaining the relationship (Bograd, 1984). In attempting to equalize the responsibility for the violence, proponents of family systems theory have implicitly or explicitly blamed (p.25) the victim. It then becomes the victim's responsibility to change her behavior to stop the violence perpetrated against her. Often treatment success is defined as keeping the relationship together, rather than stopping the abuse (Adams, 1988b; Brygger & Edelson, 1987).

"Bograd (1984) provides an excellent critique of the systemic approach from a feminist perspective. She states that systems theories are biased, in that they

blame battered women for violence while excusing the abusive man. The seriousness of violence is underemphasized by viewing it as simply one of many system problems. Systems theories imply that women are responsible for controlling their husbands' feelings and actions, while ignoring the power differences between women and men, not only in marriage, but in our culture in general. Additionally, these theories imply disapproval of nontraditional allocations of power and status in relationships (Bograd, 1984).

"Family systems theorists tend to advocate either family or marital therapy as the most appropriate intervention for domestic violence. When batterers and victims are seen together in family therapy, both minimize the violence in the relationship. Many battered women report that they were assaulted following couples therapy sessions (Adams, 1988b), and the fear of future violence will inhibit a woman talking about present or past violence (Ganley & Harris, 1978). Additionally, if a woman talks about the violence behavior of her partner, the therapy may focus on what she did to "provoke" him. If she reports ongoing violence or abusive behavior, she may be viewed by the therapist as "resistant". (p.26)

The authors also criticize individual therapy for abusers:

"When men are seen individually and intrapsychic issues are addressed, counselors are more likely to overlook or lose sight of both societal and patriarchal dynamics and power and control issues. Mental health professionals may subtly and overtly impart their own sexist and patriarchal views to their clients by support explanations that are biased against women, supporting social structures that oppress women, and using stereotypic feminine traits as models of mental health for women (Bograd, 1984). (p.55)

"By its nature, individual therapy tends to be a supportive environment. In effect, counselors may end up colluding with batterers and supporting their justifications and continued use of power. Correcting intrapsychic problems is not likely to decrease the violence if the batterer is still being rewarded for his behavior and continues to gain compliance from his partner through his violence (Adams, 1988b; Adams & McCormick, 1982; Rosenbaum, 1986)." (p.56)

On pages 273-275: After completing the therapy they propose, they list conjoint therapy as one out of seven possibilities -- and include warnings even then.

"Two critical factors should be considered when contemplating the last alternative [couple or family counseling]. The first is that the therapist should have confidence in the man's ability to react nonabusively to the stress created by couple or family counseling. Consequently, if the man has been unsuccessful in the primary abuse group, the therapist should not recommend this option or

otherwise aid the couple in entering this kind of counseling. If this is ignored, the woman may be placed at greater risk for being abused.

"The second consideration centers on the woman and her general state of mental health. If the man has successfully completed an abuse program and is eager to resume a normal relationship, and the woman has not undertaken counseling or otherwise had the opportunity to heal the effects of violence, each partner will have a different ability to negotiate reconciliation successfully.

"We believe that attempts to reconcile a relationship and raise it to a new level of wellness will be negatively affected to the extent that a woman has not attained a sense of her personal power, devised methods of protecting herself, come to grips with responsibility issues, and accessed her feelings about the abuse. Although we do not approve of inflexible policies that require that a woman enter counseling prior to helping her reconcile with her partner, we do believe that the gigantic power differential existing between (p.274) an abuser and his victim must somehow be altered before the victim can be an equal partner in the relationship. Counselors should assess these factors, preferably in consultation with the woman, before agreeing to help a couple reconcile. In most cases, we believe a woman who has not had a chance to heal may be better off completing a group counseling program for battered women prior to working on the relationship." (p.275)

Their final warning about batterer treatment:

"Twenty or more years of learning will not disappear in a few months." (p.275)

6. Barbara Pressman, *Wife-Abused Couples: The Need for Comprehensive Theoretical Perspectives and Integrated Treatment Models*," JOURNAL OF FEMINIST FAMILY THERAPY, 1(1), 23-43 (1989). Critique of family systems theory on abuse. In cases where the male partner has abused the female, couple work can only begin after she no longer fears him and they've both completed their own therapy successfully (p.33). Beginning on page 35, Pressman goes on to describe issues that come up in that later conjoint therapy.

"Studies have shown that 80% of the men who abuse their partners either witnessed abuse or were actively abused themselves as children (citation omitted). Therefore, the predilection towards abuse precedes any involvement with a woman and, consequently, the abuse cannot be viewed as a 'bilateral' response to family conflict. Abuse lies in the core of the abuser and must be addressed there with the individual, by the individual." (p.29)

"Addressing the violence in a couple context...may be interpreted by the husband to mean that ending the abuse is a shared responsibility whereby the wife is to help him with 'their' problem or whereby her behavior is partially to blame

for his actions. To make his wife responsible, for example, for reminding him that he is becoming extremely angry will serve to hold her responsible if he becomes violent because she has not fulfilled her task sufficiently. Such a strategy further reinforces the societal expectation that women are responsible for the emotional well-being of the family and erodes the possibility of violent family members taking responsibility for their own actions. Finally, unless the husband has agreed to end the violence and successfully has learned to do so, couple work may put a wife at risk of further abuse when she returns home should she voice views, needs or complaints contrary to her partner's in the counselling sessions." (pp.33-34)

"When group work is completed, when a man ceases use of violence, and when a woman has a restored sense of her own strength and power, couple work can begin." (p.40)

"Therapy for wife abuse which is facile or quick must be questioned and scrutinized most cautiously lest major problems related to wife abuse are ignored and unrecognized." (p.41)

7. Barbara Pressman, *Power and Ideological Issues in Intervening With Assaulted Women* in INTERVENING WITH ASSAULTED WOMEN: CURRENT THEORY, RESEARCH AND PRACTICE, Barbara Pressman, Gary Cameron & Michael Rothery, eds.(Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers 1989)(pp.9-19) criticizes family systems therapy and points out the gender bias inherent in it against women:

"Another model that is unwittingly political is family systems therapy. Family systems therapy has been especially criticized by feminist therapists (Avis, 1988; Bograd, 1984; Pressman, 1989) for its neutral orientation and failure to appreciate the social, economic, and political elements of society that affect women. Furthermore, systems therapy adheres to a model that dismisses causes of behavior as irrelevant and focuses on interactional patterns by family members that perpetuate and mutually reinforce dysfunctional behavior in the family. It is a theory of problem maintenance, not of causality (citation omitted). Thereby, women are indirectly blamed for their own victimization, and male perpetrators of violence are not held accountable for their violence.

"Reviewing the literature that examines attitudes toward women in therapy, Avis (1988) found subtle biases in family systems theory that result in attributing responsibility to women for family problems as well as responsibility for affecting change. This tendency exists despite the pride family therapy takes in itself for employing a blameless notion of systemic interaction where there are no victims and no villains. She further pointed out the subtle biased assumptions underlying much of family therapy practices; for example, that is primarily women's responsibility for childrearing. Consequently, children's problems are attributed

principally to inadequacies in mothers. Although there is emphasis on engaging fathers in family therapy, involvement of fathers is aimed at helping mothers out or teaching mothers more effective parenting skills.

"A parallel finding was documented by Caplan and Hall-McCorquodale (1985). In their study of nine major clinical journals over a 3-year period, they found mother-blaming prevalent in all nine journals and most strongly so in Family (p.16) Process, a prominent family therapy journal. Caplan and Hall-McCorquodale documented a tendency in clinical journals to idealize fathers, to describe them in only positive terms, and not to see their behavior or lack of specific behaviors as contributing to their children's difficulties.

"Finally, a repeated theme in family therapy practice is the unchallenged reinforcement of stereotyped sex roles (Avis, 1988; Bograd, 1984). The acceptance of traditional relationship arrangements as the ideal fails to appreciate the consequences of traditional socialization for women. This socialization renders women feeling helpless, dependent, and passive. Thereby, its promotion becomes a political act, for therapists again unwittingly endorse expectations of women that will reinforce their sense of inadequacy and powerlessness.

"Thus far, I have described two issues of power related to wife abuse. First, this phenomenon is a reflection of inequitable social norms and redressing these norms necessitates empowering women. Second, therapists hold the power to determine the cause and meaning of this symptomatic behavior and by such determinations they may: (a) wrongly hold wives responsible for their own abuse, (b) wrongly blame women for their own abuse, (c) label women in pejorative ways, or (d) fail to recognize the root causes of violence. In all of these situations, women's reality is distorted and the social norms are maintained.

"A third power issue is a value-taking role. This role necessitates therapists saying that not only is violence wrong, but also it will not be tolerated. Probation officers and child protection workers take such a role. I believe, furthermore, that it is appropriate and necessary for therapists in general to take on such a role. Part of disseminating values is mandating therapy and the use of legal authority to ensure human rights and protection (i.e., safety in the home).

Therapy and Legal Sanctions Against Violence

"Recently, the law has become quite clear on this matter and has enforced its power by making culpable and responsible any perpetrator of a violent act. Men who abuse their partners engage in much blaming and ruminating about their partners' misdeeds. However, it is irrelevant, before the law, that a wife did not

make supper on time or did not pick up groceries that day or had not cleaned the kitchen floor or stored away the children's toys. If therapists are caught up in the wife's behavior, which indeed may not be angelic, and give substance to the belief that she plays a role in her husband's violence, abusing men will continue to blame their wives. They will not recognize that the issue is the nature of their responses to events they do not like or want.

"Invoking the power of legal authority may seem to be an anathema to many therapists trained to respect the right of clients to determine their own life courses. However, this view is questionable when the individual's behavior constitutes a threat to others or when his or her own life is at risk." (p.17)

8. Daniel Willbach, *Ethics and family therapy: The case management of family violence*. (1984) JOURNAL OF MARITAL AND FAMILY THERAPY (15,1) 43-52, argues both that conjoint therapy is dangerous for the victim and unethical for the therapist.

He characterizes the basic belief of family therapy, the notion that "circular causality holds. . .each member of the system equally 'induces' behavior and has their behavior 'induced' by others. . .a vast oversimplification" in the case of domestic violence because it fails to see that everyone in the system does not have an equal amount of power (p.44). Willbach characterizes the typical interactive explanation of domestic violence as not only faulty, but also incomplete, because typically the husband is responsible for hurting his spouse and she does not desire to be hurt, nor is his abuse in their interest (p.45).

The family therapy model fails to see that "domination is not simply based on the beliefs of the family. The victim in some important sense cannot chose to react to an act of violence: Physical injury occurs to the victim according to invariant laws of physics" (p.45). As to economic control, because "it takes a certain amount of money to feed, clothe and house young children, . . .no amount of change in one's worldview is going to change this reality (p.45). The victim is constrained by these material limitations in reacting to the activity of the victimizer. Coercive power is based, to a large extent, on the effective control of material realities, not simply on ideas" (p.46).

In cases where the abuser will not contact with the therapist to end his violence "but will only agree to conjoint therapy, the therapist should not comply with this request. With this category of clients the consequences of conjoint therapy will usually be worse than no therapy. Of course, the therapist should still advise the abused family member to protect herself by all means, e.g., seeking help from friends, leaving home for a shelter, obtaining a restraint order, etc. She would benefit from individual therapy as well, but not from conjoint therapy at this point" (p.48).

Refusing to do conjoint therapy can be a powerful intervention because it "indicates that responsibility for violence lies with the individuals, not the couple or family. This is exactly what the perpetrator needs to learn as a first step toward behavior change: that

he was responsible for the violence. Typically, most batterers begin treatment with a denial of responsibility, putting the locus of responsibility, and incidentally, also the locus of control, on the victim." (p.48)

In cases where there appears to be mutual the therapist's "ethical responsibility is even more crucial. In most of these cases, the woman's violence is reactive and defensive" (p.49) making it even more important to "point out the difference between aggression and defense, and to hold the initiator accountable." (p.49)

The authors also note, "[t]he abused spouse is often incapable of speaking freely about the abuse in the [conjoint therapy] session, for fear of retaliatory abuse if she does so" (p.50). Even when both parties wish to remain together, "it is most important. . .to see an actively abusive man individually, for the content, itself, of the conjoint sessions can become the excuse for more abuse at home." (p.50)

If the husband cannot take "responsibility for his own actions, both in the sense of not blaming someone else for them and being able to control them" then Willbach feels "it becomes difficult to envision safe and effective family or conjoint therapy" (p.50). Even when he can, the author suggests a two stage treatment plan with some overlap; individual or group work with batterers for the abuser, followed by conjoint or family therapy after the violence has ended, very possibly requiring different therapists (p.50).

9. Marsali Hansen & Irene Goldenberg, *Conjoint Therapy With Violent Couples: Some Valid Considerations*, in *BATTERING AND FAMILY THERAPY: A FEMINIST PERSPECTIVE*, Marsali Hansen & Michele Harway eds. (Newbury Park, CA: Sage Publications, 1993) 82-92, is written by advocates of conjoint therapy. Nonetheless, they caution that where there is psychosis or a major personality disorder in one or both of the parties, conjoint therapy will not be receptive to conjoint intervention (p.85). [Some psychologists are now finding that most batterers have psychopathology consisting of the personality disorders which would make them unreceptive to conjoint therapy. See, e.g., Reneta Vaselle-Augerstein & Annette Ehrlich, *Male batterers: Evidence for psychopathology* in *INTIMATE VIOLENCE: INTERDISCIPLINARY PERSPECTIVES* (Emilio C. Viano ed. 1992) 147 and L. Kevin Hamberger & James E. Hastings, *Personality correlates of men who abuse their partners: a cross-validation study*, 1 *JOURNAL OF FAMILY VIOLENCE* 223, 234 and 333 (1986).] Conjoint therapy is also inappropriate if "the therapist cannot feel confident of the safety of the client, or fears for her own safety...(whether safety issues concern suicide, homicide or battering)" (p.85), i.e., when the couple is not currently involved in violent transactions (p.85) and only if the counseling first addresses and establishes safety and a cessation of the violence. (p.86)

10. Edward W. Gondolf, *Treating the batterer*. (pp.105-118 in *BATTERING AND FAMILY THERAPY: A FEMINIST PERSPECTIVE*, Marsali Hansen & Michele Harway eds.) (Newbury Park, CA: Sage Publications 1993) points out the criminological and therapeutic reasons why couples counseling is inappropriate:

"From a criminological perspective, laws regarding assault, inside or outside the home, specify a perpetrator and a victim for one illegal act -- or "count." A sentence is given, at least in principle, in an effort to punish, restrain, and/or rehabilitate the perpetrator. Increasingly, victim assistance or compensation is offered to the victim to facilitate psychological and financial recovery from the criminal act. Therapeutically, one of the fundamental principles in "cessation treatments," in general, is that the individual perpetrator take responsibility for his behavior in order to change it (Fagan, 1989). This process takes a very concentrated effort with court-mandated batterers, who are shown to have heightened levels of denial and minimization. If couples counseling is to be introduced, it is therefore generally recommended that it be after successful completion of a batterer program and after at least six months of nonviolence. As suggested previously, couples counseling may be ineffective and even dangerous with a substantial portion of batterers considered to be antisocial or sociopathic." (p.114)

In addition Gondolf states some practical reasons why couples counseling is inappropriate in domestic violence cases and why "a movement toward establishing nationwide standards for court-mandated counseling [for batterers] opposes couples counseling. . . . Many battered women are reluctant to confront their batterers or be in counseling with them for fear of reprisals, and many batterers are openly opposed to couples counseling because of their denial and projection of the blame." (p.113)

11. Frances Purdy & Norm Nickle, *Practice Principles for Working with Groups of Men Who Batter*. SOCIAL WORK WITH GROUPS (4,3) 111-122 (1981) state:

"- In counseling, the problems of the relationship cannot be the initial focus. It is too dangerous to discuss the problems of the family until all members are safe from being abused. Couple or family counseling with the abuser present should never happen until the violence has stopped and the abused is no longer afraid of the abuser. Any problems with communication cannot realistically be addressed while one is blatantly abusing power or force. To develop trust, equal communication, and mutual support necessary for solving family problems, safety must first be achieved." (p.112)

Regardless of what technique is used, "[s]afety should always be the first and last consideration" in any therapy. (p.113)

12. Michael Lindsey, Robert W. McBride & Constance M. Platt, *AMEND PHILOSOPHY AND CURRICULUM FOR TREATING BATTERERS* (Littleton, CO: Gylantic Publishing 1993) on pages 8-9 and 37 criticize joint therapy, saying it is dangerous and only appropriate when the batterer has learned to manage his anger and determined never to use violence again.

13. Andrea J. Sedlak, *Prevention of Wife Abuse*, in HANDBOOK OF FAMILY VIOLENCE (Vincent B. Van Hasselt, Randall L. Morrison, Alan S. Bellack & Michel Herson eds.) (New York: Plenum Press 1988) 319-358, noting that the advisability of conjoint couples counseling has been long debated, states:

"Those opposing conjoint approaches argue that violence is an individually learned behavior and that the abuser must assume responsibility for the violence. First, opponents doubt the safety and efficacy of a joint approach in the abuse of a strict no-violence contract. There is real concern that conjoint therapy may compromise the victim's safety and exacerbate the violence if used before the man has achieved control over his violence (citations omitted). Moreover, the battered woman may well be reticent to disclose anything negative in front of her abuser if she risks violent retaliation. Second, critics argue that the violence must be the first and central issue in any treatment program. Conjoint therapy is seen as minimizing the importance of the violence by focusing equally or even predominantly on other issues (Bograd, 1984; Edelson, 1985). Third, the conjoint approach is said to cloud (if not distort) the issues of responsibility for the violence (citation omitted). It can give the impression that the violence is caused to some degree by the woman and can lead the abuser to feel it is not really his problem (citations omitted). At one extreme are those family therapists who are even unwilling to label the battered woman as a victim (citations omitted). More moderate clinicians may acknowledge the woman's victimization, but imply that she can (and hence should) control her husband's feelings and actions, which thereby attenuates his responsibility for the violence (citation omitted). Fourth, traditional couples therapy is oriented toward improving (p.343) the relationship, and it subordinates individual needs to this goal. Critics emphasize that intervention with battering couples must focus on strengthening the individuals first, and relegate the survival of the relationship to a lesser priority (citation omitted).

"Less extreme viewpoints on both sides of this controversy have recently emerged. On the one hand, Bograd (1984) has noted that adopting a systemic framework in thinking about the problem does not require that one use conjoint therapy. In line with this stance, some family systems practitioners have also taken the somewhat unorthodox view that a systemic approach does not preclude holding the husband to be solely accountable for the violence (citations omitted). On the other hand, those who oppose the general use of conjoint therapy do acknowledge that it might be a useful follow-up to individual work with the man in those cases where the couple chooses to stay together (citation omitted) and where the violence has stopped (citation omitted). As a result, no-violence contracts are becoming a commonly imposed precondition to the use of conjoint couples therapy and a number of those who offer conjoint couples counseling have established ending the violence as their highest priority goal (citation omitted).

"Again, evaluation studies are sadly lacking." (p.344)

14. Evan Stark & Anne H. Flitcraft, *Spouse Abuse* in *VIOLENCE IN AMERICA: A PUBLIC HEALTH APPROACH* (Mark L. Rosenberg & Mary Ann Fenley eds.) (New York: Oxford University Press 1991) 123-157, recommend "behavior-oriented counseling (particularly as an alternative to jail), which emphasizes the inappropriateness of traditional male roles, respect for female independence, taking responsibility for violence acts, and learning nonviolence means of responding to interpersonal tension" (p.151) for batterers as the best way to treat domestic violence. It is noteworthy that they do not recommend couples counseling as a way to treat domestic violence.

The American Medical Association has promulgated a model protocol, Diagnosis and Treatment Guidelines on Domestic Violence (Chicago, IL: AMA 1992), which states:

Couples' counseling or family intervention is generally contraindicated in the presence of domestic violence. Attempts to implement family therapy in the presence of ongoing violence may increase the risk of serious harm. The first concern must be for the safety of the woman and her children. (emphasis in original) (p.12)

IV MATERIAL CITED

- Adams, David (1988b). Treatment models for men who batter: A profeminist analysis. In K. Yllo & M. Bograd (Eds.), *FEMINIST PERSPECTIVES ON WIFE ABUSE*, Newbury Park, CA: Sage.
- Adams, David & McCormick, A.J. (1982). Men unlearning violence: A group approach based on the collective model. In Maria Roy (Ed.), *THE ABUSIVE PARTNER*, New York: Van Nostrand Reinhold.
- Avis, J.M. (1988). Deepening awareness: A private study guide to feminism and family therapy. *JOURNAL OF PSYCHOTHERAPY AND THE FAMILY*, 3, 15-46.
- Bograd, Michele (1984). Family systems approach to wife battering: A feminist critique. *JOURNAL OF ORTHOPSYCHIATRY*, 54, 558-568.
- Brygger, Mary Pat & Edelson, Jeffrey L. (1987). The domestic abuse project: A multisystems intervention in woman battering. *JOURNAL OF INTERPERSONAL VIOLENCE*, 2(3), 324-336.
- Dobash, E. & Dobash, E. (1983). Unmasking the provocation excuse. *AEGIS*, 37, 57-68.

- Edelson, J.L. & Brygger, M.P. (1986). Gender differences in reporting of battering incidents, *FAMILY RELATIONS*, 35, 377-382.
- Ganley, A. (1981). Court-mandated counseling for men who batter: A three day workshop for mental health professionals. Manual available from the Center for Women's Policy Studies, Washington, D.C.
- Jouriles, E.N. & O'Leary, K.D. (1985). Interspousal reliability of reports of marital violence. *JOURNAL OF CONSULTING AND CLINICAL PSYCHOLOGY*, 53, 419-421.
- Pressman, Barbara (1989). Wife-abused couples: The need for comprehensive perspectives and integrated treatment models. *JOURNAL OF FEMINIST FAMILY THERAPY*, 1, 23-43.
- Rosenbaum, A. (1986). Group treatment for abusive men's process and outcome. *PSYCHOTHERAPY*, 23(4), 607-612.
- Schechter, Susan (1982). *Women and male violence: The Visions and Struggles of the Battered Women's Movement*. (Boston: South End Press).
- Szinovacz, M. (1983). Using couple data as a methodological tool: The case of marital violence. *JOURNAL OF MARRIAGE AND FAMILY*, 45, 633-644.
- Walker, Lenore E. (1984). *The Battered Woman Syndrome* (New York: Springer Publishing Company).