CHAPTER

6

Intimate Partner Violence and the Ecology of Therapy

In previous chapters, we examined the complexity of ethical decision making while attending to concerns such as acculturation and dissonance, layers of values and sources of power, foundational principles, ethical traditions, and the unique aspects of marriage and family therapy. We consider selected contemporary ethical issues in Chapters 7 and 8. We also offer a casebook approach to considering the implications of the American Association for Marriage and Family Therapy's (2001) code of ethics in Chapter 9.

This chapter, however, features an in-depth example in which we apply the array of elements in the ecology of therapy that therapists may consider when faced with an ethical dilemma. Our overall objective for this chapter is to illustrate the conceptual and procedural aspects of ethical care discussed in previous chapters in an applied client situation. We have selected a difficult and complicated client situation (i.e., intimate partner violence) to demonstrate the distinctive ethical principles and practical concerns a therapist would encounter. Our intention is to present a rationale for ethical decision making and care reflecting the concerns we have emphasized so far in the text.

A variety of questions will probably emerge as you read this chapter: What are the boundaries between who I am and what I do when faced with violence affecting clients? How can I sustain my objectivity? Should I sustain my objectivity? What does a systemic viewpoint mean in cyclical patterns of violence? Are the foundational ethical principles applicable? What about client safety? What about children? Where do I proceed with the Battle for Structure and the Battle for Initiative? In reviewing the various ethical considerations related to this topic, we hope to offer a framework that consolidates our earlier discussions and that prompts similar thought for the remaining chapters.

INTIMATE PARTNER VIOLENCE: AN OVERVIEW

The terms *domestic violence* or *intimate partner violence* (IPV) have emerged in the professional literature as descriptors of chronic as well as episodic patterns of abuse, ranging from harsh criticism to aggressive brutality, between adults in intimate relationships (Catalano, 2009;

Danis & Lockhart, 2003). For purposes of this chapter, we use these terms interchangeably, although IPV has become the more common term for describing abusive relationships among both married and unmarried couples. Distinguished from criminal acts that may occur between strangers, such as assault, battery, or other similar crimes, IPV concerns perpetrating hostility of a more hidden nature (M. P. Johnson, 1995; McFarlane & Malecha, 2005). Unlike other forms of aggression, IPV often features the unfortunate yet compelling elements of intergenerational and gender-specific traditions promoted within a family or a community (Bevan & Higgins, 2002; J. Brown, 2004).

Acts such as child abuse or elder abuse are actually forms of domestic violence, though they are typically distinguished in duty-to-warn and duty-to-protect legal mandates that compel action on the part of therapists in order to protect those who may be unable to protect themselves (Buttell, 2001; L. E. Walker, 2000). The distinction between adult partner victimization and child abuse or elder abuse has been the myth of equality among adults, that is, that an adult *could* choose to leave the relationship, should one wish to do so, unlike less powerful children or aged adults. Over time, however, findings have indicated that such equity does not exist, particularly regarding the options for alternate living arrangements available to victims (Kurri & Wahlstrom, 2001; Sharman, 2001; Simpson, Doss, Wheeler, & Christensen, 2007). Originally described as "wife beating," domestic violence initially concerned violence perpetrated by a husband against his wife. From this background emerged the term *battered-wife syndrome* or similar references to chronic yet inescapable victimization (Holtzworth-Munroe & Stuart, 1994; L. E. Walker, 2000). In more contemporary times, views on IPV have been amended to reflect other relationships (e.g., cohabitation, same-gender couples, and so on).

IPV is a complex and multifaceted condition for marriage and family therapists to encounter. Holtzworth-Munroe and Stuart (1994) identified three dimensions of domestic violence as the basis for distinguishing subtypes of offenders. They noted offenders differ according to *severity of violence* (e.g., shoving, severe brutality, and so on), *generality of violence* (i.e., violence toward partner or toward others) and *presence/absence of psychopathology/personality disorders*. Within this framework, a single unitary view of IPV is unlikely. Similarly, M. P. Johnson and Ferraro (2000) identified two types of intimate violence: (a) male power and dominance and (b) mutual conflict between partners. Although the first of these two types coincides with the long-standing notions of battered-wife syndrome, the second suggests a more reciprocal pattern of conflict within a relationship. However, these authors were quick to point out that despite such a pattern of conflict between partners, the majority of such circumstances led to the wife as the victim. M. P. Johnson (1995) offered an insightful view of the multidimensional nature of IPV related to *patriarchal terrorism* and *common couple violence*. The former represents an omnipresent and chronic pattern of dominance and maltreatment involving both violent and nonviolent means of control, while the latter is more episodic and situation specific and more likely to include both partners, though more severe expressions continue to be associated with males. From these few works, one can see that IPV can have a number of faces, but all are scarred in some ways (Catalano, 2009).

As with most any circumstance of oppression or harmful acts toward another person, speculation about causes of IPV have been offered in the professional literature. Thus far, no single cause has yet been identified (Holtzworth-Munroe, Meechan, Herron, Rehman, & Stuart, 2000; Johnson & Leone, 2005). Instead, discussions of the origins of domestic violence consider co-occurring or contributing factors and conditions that may promote or sustain such patterns. These

ors appear to be both psychological/experiential and environmental in nature. Chang and nders (2002) indicated that a history of child abuse, antisocial tendencies, and a predilection ard expressing anger in violent ways appeared to be common among victimizers. Bevan and gins (2002) observed that a variety of types of childhood maltreatment contributed to tenden- s of violence; including (a) physical abuse, (b) psychological maltreatment, (c) sexual abuse, neglect, and (e) witnessing violence. J. Brown (2004) speculated that from chronic childhood eriences such as these, the development of shame as a significant aspect of domestic violence uld not be discounted. Other variables, such as unemployment, poverty, stress, suicidal ation, and homelessness, also have been noted as co-occuring factors in IPV (Bergen & kovic, 2006; Danis & Lockhart, 2003; Gerlock, 2001; National Coalition Against Domestic olence [NCADV], 2009).

Data from the Centers for Disease Control (CDC, 2009) regarding IPV indicate that ap- oximately 5 million incidents are reported annually in the United States. These incidents result nearly 3 million injuries and nearly 1,600 deaths per year. Additionally, a complete picture re- arding the incidence of IPV will likely never be known since decisions not to report are com- ion among victims because of fear of retaliation or possible harm to others, especially children McFarlane & Malecha, 2005; NCADV, 2009).

A growing awareness of the prevalence of abuse and violence in families began in the 970s. Before that time, "intimate partnerships" were "believed to emanate from higher irtues like romantic love, affection, or a natural unity of interest" and thus were "exempt from considerations of justice" and ethics (Jory, Anderson, & Greer, 1997, p. 401). However, con- textual therapists brought the concept of justice with its ethical implications into the field of marriage and family therapy especially through the writings of Boszormenyi-Nagy (e.g., Boszormenyi-Nagy & Sparks, 1973). The focus in this approach was the intergenerational na- ture of justice, in which justice was defined as the "long-term preservation of an oscillating balance among family members, whereby the basic interests of each are taken into account by the others in a way that is fair from a multilateral perspective" (Boszormenyi-Nagy & Ulrich, 1981, p. 160).

In examining the considerations relevant for marriage and family therapists in ethical ac- tions concerning IPV, we offer an applied view of the issues discussed in previous chapters. To begin this discussion, we posit that marriage and family therapists, as well as their clients, have cultural and value heritages that affect their viewpoints concerning IPV.

CULTURAL, VALUE-POWER, AND SYSTEMIC CONSIDERATIONS

Perhaps the most distinguishing characteristic of IPV is its contextual framework within fa- milial and social cultures. A notable pattern of intergenerational repetition has emerged from the literature to suggest that many who resort to violence in instances of domestic dis- agreement or frustration believe that it is both allowable and even deserved (CDC, 2009; Danis & Lockhart, 2003; McCloskey, Treviso, Scionti, & Posson, 2002; NCADV, 2009). Anecdotal stories appear in popular literature and movies suggesting that a "new victim" of domestic violence will "simply have to learn that it's the way things are done around here" or that "it was the same for me with your father, so get used to it." Clearly, established pat- terns of violence are varied in their origins and unique in their effects. Consider the follow- ing case example.

CASE 1 *Walter's Unexpected Encounter*

Returning from a Saturday morning trip to the hardware store with his son, Walter turns into the parking lot of his apartment complex. They observe a man yelling at a woman (presumably his wife) and then slapping her repeatedly. Walter watches as his neighbor runs to assist the victim. Pulling the husband away from his wife, the neighbor is surprised by a jarring blow to the back of his head. The wife has swung her purse with great vigor and connected with the neighbor's head. Walter and his son leap from their car to become involved in the melee and hear an approaching police cruiser (called earlier by the neighbor's daughter). The husband sprints to his car, the wife enters as his passenger, and they speed away from the parking lot as Walter observes the wife laughing and hugging her husband as they disappear into the traffic pattern. His son is baffled and asks, "How can she defend him when he hurt her that way?" Walter offers his explanations, knowing that they will be neither definitive nor adequate for his son.

Various cultural dimensions have been identified as considerations affecting IPV, including gender (Bergen & Bukovic, 2006; Carney & Buttell, 2004; Henning, Jones, & Holdford, 2003; M. P. Johnson & Leone, 2005), race (Buttell & Carney, 2004; Mederos, 2007; Sharman, 2001; Yoshika & Choi, 2005), and ethnic/national origin (Fulcher, 2002; Kasturirangan & Williams, 2003; Lee, 2003; McCloskey et al., 2002; Phiri-Alleman & Alleman, 2008). Others have identified considerations such as religion (Foss & Warnke, 2003), sexual orientation (Kaschak, 2001; Peterman & Dixon, 2003; A. Robinson, 2002), and disability (Hassouneh-Phillips & Curry, 2002) as critical aspects to consider in patterns of IPV. Although psychiatric conditions or forms of emotional impairment may contribute to IPV, the acceptability of episodic or chronic aggression among some cultural groups is not uncommon (Mederos, 2007; Pedersen, 1996; Thomas, 1998). Such patterns and customs compel marriage and family therapists to consider heritage and social circumstances of clients as significant factors in avoiding the nondiscrimination elements of ethical codes noted in previous chapters. If a question exists for ethical propriety on the part of marriage and family therapists encountering IPV, does such a question pit concerns about victimization against respect for heritage and social or family customs? (Simpson et al., 2007; C. Williams, 1999).

Our discussion in Chapter 1 emphasized the importance of *value-sensitive care* related to therapist duties, particularly in *establishing the limits of responsibility*, *accepting what is*, and *clarifying expectations*. This discussion also emphasized the interactive nature of *client motivation*, *risk*, and *adaptation* as well as *systemic inequities and honest evaluations* as critical preliminary considerations for balancing change and stability in the therapeutic process.

We have also examined the interaction between *layers of values* and *sources of power* affecting marriage and family therapists. The *personal values* of the therapist may be particularly important when faced with a circumstance of IPV. A therapist may find such behavior to be unacceptable and may seek an outcome consistent with his or her preferences. The personal values of the therapist may clash with those of the client or family, however, particularly if the victimization is sustained in cultural or familial origins. By contrast, a therapist impaired by an unresolved history of victimization with an intimate partner may minimize its significance or may overidentify with the victim to the extent of undertaking a personal crusade for justice. As one can see, decisions deriving from the personal layer of values held by the marriage and family therapist may be complex and even interrelated with those of the family.

the *professional layer of values*, a significant consideration for the therapist may be a / of duties. Attending to concerns about *client safety* and *therapist role* (e.g., neutrality, :ion, and so on) generally coexists in a balanced manner in therapeutic relationships. In ; of IPV, however, duties related to client safety may outweigh duties related to therapist h is the case in instances of duty-to-warn or duty-to-protect obligations on the part of a . For some, becoming an advocate for client safety may be the more compelling person- ofessional value. However, such a role may impede, if not clash with, the role of therapist e or she act in a manner that could be inequitable toward other members of the family, rly the victimizer.

:itutional values associated with social custom, legal precedent, and even risk manage- iability may converge or conflict with personal or professional layers of values. For ex- marriage and family therapist who wants to reserve the primacy of the "therapist" role : conflicting institutional mandates for advocacy or even referral in cases of domestic vi- 3y contrast, all three layers may support insistence that the victim seek safety, a role that :arly threaten a subsequent therapist function with both the victim and the victimizer.

.e sources of power also affect therapists' options to influence circumstances of IPV. As :viously, the use of *legitimate power* to compel the actions of others is often aligned with ɔnal values. To influence clients using the power to compel certain behaviors on the part imized client could yield short-term gains in safety. However, employing such an ap- hould be considered in light of the potential for long-term dependence on agencies or individual therapist for decisions and protection.

ferent power, typically aligned with personal values, could be a particularly troublesome f attempting to influence victims and perpetrators in an IPV circumstance. The capacity nce via referent power relies on one's persuasive ability charm, manipulate, or impress ased on one's status. For example, a therapist who has had a history of victimization in relationship might be able to invoke referent power with a client in a similar circum- To do so, however, can create unrealistic expectations by clients who might assume that ınd care from their "kinship therapist," including actions such as financial assistance, tation, housing, and other forms of protection. The outcome of such an approach is in- : The therapist attempts to redefine the relationship with boundaries, the client feels ed, and the therapist's capacity to influence is compromised.

ır these reasons, reliance on *expert power*, informed by professional values, emerges as t viable framework for influencing clients in an IPV circumstance. Toward this end, nsitive care can be tempered by reality and professionalism, thereby positioning the ther- be a reliable resource who advocates and supports client decisions and welfare.

urlier discussions featured an examination of *systemic epistemology*. As was noted, the : viewpoint continues to have considerable influence on conceptual and applied aspects age and family therapy. However, the *feminist critique* offered in this review specifically zed domestic violence as a circumstance in which, if applied in a mechanistic fashion, :mic perspective suggests that the victim seeks and desires violence for the sake of stabili- his point with which feminist-informed authors disagree mightily. In a related discussion ble exceptions to systemic epistemology, those emphasizing *self in the system* suggested ving one's self as "one among many" failed to acknowledge individual uniqueness. Such ın could serve to sustain the oppressive nature of IPV, particularly when a victim considers ɔtions as beyond reasonable hope. When considering these two points regarding IPV, ts espousing a systemic viewpoint should take great care in any conclusion that a victim ly chooses to stay in a violent relationship.

A recurring discussion in previous chapters has concerned the Battle for Structure and the Battle for Initiative (Napier & Whitaker, 1978). Thus far, our examination of elements related to ethical considerations in circumstances of IPV has focused on elements of values and roles. A clear distinction between these battles often is not realistic in instances of IPV, however. To manage therapy by requiring victim and victimizer to convene in order to win the Battle for Structure could possibly enrage the victimizer and endanger the victim. Considering the Battle for Initiative to be fully the responsibility of all parties could be based on an erroneous assumption of equity in power and control, which research literature conclusively demonstrates does not exist (Catalano, 2009; Danis & Lockhart, 2003; Gerlock, 2001; Kurri & Wahlstrom, 2001). Similar to many conceptual notions, a neat package of distinction is frequently impossible. However, ethical principles, traditions, and codes can be informative in terms of decisions and actions.

REFLECTION 6–1

Does any dissonance emerge as you consider the layers of values affecting your views and preferences as a therapist faced with an IPV circumstance? Can you sustain expert power and professional values in your contribution to the ecology of therapy with victims? What about perpetrators?

PRINCIPLES, TRADITIONS, AND UNIQUENESSES

Some studies of IPV circumstances suggest that a victimized partner should be encouraged by the therapist to leave the abusive relationship (Betancourt, 1997; Roberts, 1996; Stith, Rosen, McCullum, & Thomsen, 2004). But the issue is often complicated by the acculturation of the victim or victimizer to the extent that a pattern of violence is viewed as normal or expected (Bograd, 1999; Kasturirangan & Williams, 2003; Sharman, 2001). Add to this equation the complexity of cultural differences, and discussions of *welfare*, *due care*, and *competence* become even more provocative. For example, Phiri-Alleman and Alleman (2008) observed,

> Within the European American model, helping systems establish safety for women and children through separation of the victim from the offender and, often, from the community. Although this practice is questionable in its culture of origin, in which the ideal of individuality and autonomy have great resonance, many women of color may more easily accept protective orders that stress nonviolence but allow the victim to remain with the offender (Mederos, 2007). In fact, for some cultures, such separation could be experienced as more traumatic than the abuse itself. (p. 157)

Ethically, a recommendation of separation creates a dilemma: Should the therapist encourage the victim to leave the relationship? On one side of the question is respect for one's self-determination and an assumption that the victim possesses sufficient psychological competency to act in his or her own best interests. On the other side is the conviction that the experience of the victimization cycle sufficiently justifies compromising the client's autonomy. The five principles of Beauchamp and Childress (2009) can guide therapists in deciding what action would best serve the standard of primacy of the client's welfare.

Beneficence promotes the notion that therapists confer benefits and promote clients' well-being. The literature describing chronic patterns of IPV often notes that separation from

victimizer will maximize a victim's psychological growth, facilitate a more objective assessment of the relationship, and reduce the immediate potential of injury or death:

> Only after women feel protected from another assault, can they begin to deal with the reality of the battering situation. (L. Walker, 1981, p. 88)
>
> The symbiotic dependency bonds must be broken and each partner taught independence and new communication skills. (McG Mullen & Carroll, 1983, p. 34)
>
> Marriage counseling cannot proceed while the wife is living in fear. (Wentzel & Ross, 1983, p. 427)
>
> Men who believe they have a right, or entitlement, to sex with their intimate partner will often use emotional pressure or coercion to force their partner to comply (Phiri-Alleman & Alleman, 2008, p. 157)

Beneficence compels that benefits and harms be balanced; that is, positive outcomes must be weighed against the risks (Beauchamp & Childress, 2009; Bograd & Mederos, 1999). Studies have shown that victims of IPV, most frequently battered women, who leave the batterer and go to a shelter where help is available have far greater success in overcoming the emotional and motivational deficits induced by the feelings of helplessness they experience while remaining at home (Ehrensaft & Vivian, 1996; L. Walker, 1984). Less success in overcoming these feelings of helplessness has been reported when victims remain with abusive partners and try to change the relationship to one with minimal violence (Flax, 1977; Greenspun, 2000). Such a view was probably held by the victim discussed in Walter's case earlier in this chapter. Because the benefits outweigh the harms, a therapist could assert the value for a victim to leave the relationship.

The principle of *nonmaleficence* is epitomized by the adage "above all, do no harm." Not encouraging a victim to leave circumstances that are certainly dangerous appears to violate this principle. Although a therapist may not be inflicting the harm personally, he or she is allowing clients to return unchallenged and unaided to a setting in which they will probably be abused in the future (Goldner, 1999; Simpson et el., 2007; L. Walker, 1984; Wentzel & Ross, 1983).

The principle of *justice* demands that clients with equal needs not be discriminated against through either a therapist's incompetence or denial of treatment. However, clients with unique needs that require special interventions are entitled to unique treatment (S. J. Freeman, Engels, & Altekruse, 2004; Huston, 1984). Intimate partners victimized by domestic violence display unique characteristics and needs because of the psychological reactions concomitant to living in a violent environment. Some authors have compared victims of IPV to hostages who are unable to escape life-threatening or identity-threatening situations characterized by social isolation and dependency, and who then form deep attachments to their captors as a form of "patriarchal terrorism" (M. P. Johnson, 1995, p. 285). Because of this trauma, they are unable to assess their real plight or risk; the perpetrator's intermittent but persistent abuse has destroyed their subjective realities (Bergin & Bukovic, 2006; Graham, Rawlings, & Rimini, 1988; Painter & Dutton, 1985). Justice, therefore, lends support to acting on behalf of a victimized partner.

Fidelity emphasizes the importance of therapists' faithfulness and loyalty to clients. L. Walker (1981) reported that battered women generally believe that their batterer's charm will seduce anyone, even professionals: A "battered woman may misinterpret any attempt at developing a therapeutic alliance with the batterer" (p. 85). Victimized clients must be assured that the therapist will be loyal to them above any connection to the victimizer or to the unconditional maintenance of the marriage (Vatcher & Bogo, 2001). Fidelity also demands that therapists be truthful with clients, suggesting that the therapist has an obligation to inform a victimized client of

TABLE 6-1 Ethical Considerations Regarding Client Rights to Autonomy and Self-Determination

American Association for Marriage and Family Therapy (2001)
"Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions."

American Counseling Association (2005)
"Counselors encourage client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relationships."

American Psychological Association (2002)
"Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making."

International Association of Marriage and Family Counselors (2005)
"Marriage and family counselors respect the autonomy of the families with whom they work. They do not make decisions that rightfully belong to family members."

National Association of Social Workers (2008)
"Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs."

research findings indicating that it is dangerous and not psychologically helpful to return to the batterer (Goldner, 1999; Graham et al., 1988; Huston, 1984; L. Walker, 2000).

The ethical dilemma created by potential infringement of the client's *autonomy* is less easily resolved. Autonomy proposes that an individual has a right to make his or her own decisions if those decisions do not violate the rights of others. Consider the entries in the various ethical codes relative to autonomy and rights to choice noted in Table 6-1.

To tell a client to leave home can be viewed as an infringement of his or her autonomy. It also can be argued that respect for the autonomous functioning of the victim is vital because of the vulnerable and dependent nature of the victim, particularly given the inherent transference aspects of the therapist–client relationship. Transference issues with battered women tend to include withholding anger from or being overly compliant with persons of authority (Heppner, 1978; McG Mullen & Carroll, 1983; Stith et al., 2004). Therapists must be cautious not to misuse their position as the object of the transference phenomenon by being overly directive with these clients (Huston, 1984; James, 2008).

One's rights to autonomy can be affected by his or her level of psychological competence. An individual whose psychological competence is limited is unable to make consistent rational judgments. Mills (1985) described battering victims' debilitating use of minimization (e.g., "compared to others, my problems are small") to mistakenly justify their circumstances and to allow them to tolerate violent marriages. Similarly, Ferraro and Johnson (1983) described how women "rationalized" being abused—by saying such things such as "I asked for it," "He's sick," and "He didn't injure me"—and demonstrate how these rationalized accounts prevent the women from seeking help. Gondolf (2002) noted that such patterns may be reflective of self-deception to avoid further emotional deterioration and loss of self-worth, particularly in a perceived circumstance of inescapable danger.

Victimized partners sometimes experience a form of learned helplessness because of a ınsistent and well-reinforced message that nothing they can do will change their situation. ɛcause victimized partners consequently can become immobilized, they may be considered as ıving limited psychological competence and therefore in need of someone to assist them to get ıt of what they see as a hopeless situation. In such a situation, the marriage and family therapist faced with a compelling question: Is this victim capable of an autonomous decision?

Victims of IPV also can be immobilized by a state of extreme fear. Many victims of violent rimes become reduced to an infantile obedience to and cooperation with their attacker. ymonds (1979) suggested that a victimized woman who follows this response pattern "experi- nces terror which traumatically infantilizes her" (p. 169). Victims often remain in abusive rela- onships out of fear of the consequences of leaving. These and many other findings suggest that ictims of domestic violence, both male and female, are in need of directive assistance (e.g., ɔreenspun, 2000; Mederos, 2007; Vatcher & Bogo, 2001).

In an earlier chapter, we examined the nature of secrets in couple or family relationships. ʻor some, IPV may represent a *taboo topic* that is not to be addressed by either those in the sys- em or those outside the system, such as a therapist. Thus, an effort by a marriage and family herapist to discuss domestic violence may be rejected on the basis that it is "too personal" or 'not the reason we've come to see you." Despite such boundary setting by clients, therapists are ɜenerally expected to examine other issues of safety (e.g., suicidal ideation, intentions to harm ɔthers, and so on) in the course of therapy.

A related discussion concerned the nature of *triangulation* in marriage and family therapy. Some therapists may elect to sacrifice neutrality associated with their role as a therapist in favor of assisting a victim to find safety. In such cases, the likelihood of perceived triangulation of the victimizer by the victim and the therapist could be formidable, possibly to the point that a refer- ral to another therapist would be in order.

To this point, we have considered applied aspects of the previous chapters of our text regarding therapists faced with a situation of IPV. Both professional literature and practice traditions offer insights about the various considerations the practitioner faces. At some point, however, the therapist must consolidate the available information and make a good-faith decision. Otherwise, a delay in decision making reflects decision by indecision, an approach of passivity clearly in conflict with the active nature of *beneficence.*

REFLECTION 6–2

Review Figure 1–1 in Chapter 1. This figure depicts the struggle for balancing external factors and internal factors for ethical practice by therapists. Do you have balance between the internal and external factors affecting your approach to serving clients in an IPV circumstance? If not, which factors seem to weigh more heavily: internal or external?

DECISION-MAKING MODELS AND OPTIONS FOR RESOLUTION

Marriage and family therapists are increasingly being asked to intervene in cases of IPV (Bograd & Mederos, 1999; Eisikovits, Edleson, Guttmann, & Sela-Amit, 1991). Yet family therapy can be at odds with traditional approaches in its determination that problems exist not in a single individual but between and among family members. This basic tenet of family therapy has been

interpreted by many to imply that neutrality on the part of the therapist should be the norm in cases of domestic violence:

> Violence can draw the therapist into taking charge of others' lives, a role that does not enhance the process of therapy. Violence also draws in helping systems to protect the "innocent" and "powerless" members of the family. Such a band-aid approach does not begin to resolve the issues which lead to violence. Quite to the contrary, it seems to perpetuate them. (Combrinck-Graham, 1986, p. 69)

The clinical debate about what type of approach is most appropriate in cases of IPV has tended to be narrowly limiting, couched in terms that argue for one approach at the exclusion of another (Eisikovits et al., 1991; Simpson et al., 2007). Some have suggested that standardized approaches to evaluation and intervention can assist in resolving ethical dilemmas faced by marriage and family therapists (T. W. Miller, Veltkamp, Lane, Bilyeu, & Elzie, 2002; Stith, Rosen, & McCullum, 2002). Best practices emphasize separation of the victim from the victimizer for a period of time, followed by psychoeducational approaches to skills building and resocialization (Goldner, 1999; Greene & Bogo, 2002; Shapiro, 1986) and possible multiple couple therapy (Stith et al., 2004).

Buttell (2001) proposed that, despite efforts of compassion and understanding in therapy, many chronic victimizers may not have established the stage of moral development even to desire ending violence in domestic conflict. In addition, possible cultural and familial traditions may create a situation in which some abusers do not believe that a problem exists. Concerning decision-making matters encountered by therapists faced with circumstances of domestic violence, Kurri and Wahlstrom (2001) noted that the morality of counseling involves a curious balance of advocating for client rights to choose versus a "normative and public ethic" that advocates "prescribing the ideal of a good life" (p. 188). In their discussion, these authors noted that the tension between these two positions appears to stem from the perceived weakness of the victim who might otherwise choose a more desirable situation. In other words, Buttell (2001) seemed to ask if some victimizers possessed the moral compass for change, whereas Kurri and Wahlstrom (2001) appeared to suggest that therapy with a weak and confused victim obliges the therapist to choose "the better life" on behalf of the client. These two entries in the professional literature converge to form the crux of this ethical dilemma: What assurances exist about the aftermath of a therapist's decisions? Is there hope for rehabilitating the victimizer? Does the therapist have an obligation to prescribe "the ideal of a good life" for the victim? In many ways, the crux of the decision may pit *matters of safety* against *matters of autonomy*, each of which is relevant to institutional, professional, and personal layers of values affecting the ecology of therapy.

In Chapter 3, we encountered models of ethical decision making. Kidder (1995) noted that *end-based decisions* involve the greatest good for the greatest number; *rule-based decisions* involve meeting obligations to a code, regardless of the outcome; and *care-based decisions* involve demonstrating compassion for a unique situation. From these options, the therapist who emphasizes a rule-based approach may conclude that the primacy of code derivatives such as client autonomy, nondiscrimination, and restraint in imposing personal values are best served by acceptance of the taboo designation of IPV with clients, thereby avoiding its consideration. Such a position could be bolstered by the previous comments offered by Buttell (2001) and Kurri and Wahlstrom (2001). By contrast, the therapist may conclude that the end result of greatest good to the greatest number would stem from preserving options for future changes and thus would advocate for compromising neutrality to ensure client safety. A similar outcome could derive if the therapist takes a care-based approach that emphasizes respect for the uniqueness of the

circumstance, including unique co-occurring psychological, environmental, and cultural factors, but that insists on valuing freedom from destructive obligations.

Chapter 3 also featured a discussion of the *four processes* associated with Kitchener's (1986) decision-making model for ethical dilemmas. *Process 1* of this model concerns sensitivity, knowledge, and perceptiveness to interpret that a situation requires an ethical decision. Despite many persistent questions and uncertainties surrounding IPV, its prevalence among a wide array of relationship patterns and the systemic (even intergenerational) nature of the harm it can cause would seem to prompt a principled and virtuous therapist to action. *Process 2* of the Kitchener model concerns the formulation of an ethical course of action. Kitchener emphasized an *ethical course of action* since actions reflecting intuition at the personal layer of values may not be supported as ethical at the professional or institutional layer of values. In the case of IPV, any course of action selected by a therapist should be examined critically against ethical codes, foundational principles, and ethical theory. For each of these tiers, a decision to support safety for the victim seems justified.

Process 3 of the Kitchener model concerns the integration of personal and professional values in a decision. According to Kitchener, this process is particularly critical because one must address inequities and imbalances in imprecise decisions. Think for a moment: What creates a dilemma? In circumstances with obvious issues and established procedures, clarity is not a problem; no dilemma exists. When faced with competing obligations, values, perspectives, and traditions, however, the lack of clarity can stymie even the most informed and experienced professional. Kitchener accentuated the term *integration* for this process to convey the necessity of commitment to action rather than a simple exercise in logic and deduction.

Process 4 of the Kitchener model concerns the end product of the model: action. Acting without the commitment of process 3 may leave one open to dissuasion. However, commitment to a course of action will not offset ambiguity or even the risk of repercussions. Taken together, these two processes suggest that once a therapist examines his or her role in the balance of fairness concerning IPV, advocating for client safety is justifiable and grounded.

The Koocher and Keith-Spiegel (2007) model discussed in Chapter 3 features a systematic and sequential approach to ethical decision making. However, unlike the elements of the Kidder and Kitchener approaches, this model emphasizes procedures over values. In circumstances such as IPV, the impact of value-based care is inescapable throughout the institutional, professional, and personal layer of values. Thus, the application of the Koocher and Keith-Spiegel model may assist in clarifying matters of fact and procedure but may be somewhat impersonal for such a value-laden circumstance as IPV.

From the previous examination, it appears that many elements of ethical tradition and rules, reciprocal valuing in the therapy relationship, and decision-making frameworks favor the systemic inequity of acting to ensure safety for the victimized partner. However, what actions should be taken? In the majority of circumstances, encouraging the victim to leave the violence is indicated. But what then? Decisions rarely occur in a vacuum and rarely fail to lead to consequences, anticipated and otherwise. A significant aspect of ethical action is the aftermath of such decisions.

REFLECTION 6–3

Which approach or combination of approaches seems to be most compelling for your view on client care in an IPV circumstance? Do you find resolution of your dissonance? Do you find balance between external and internal factors affecting the ecology of therapy?

TREATMENT ALTERNATIVES: CHOICES AND STIPULATIONS

It seems ethically justifiable to encourage a partner in a violent intimate relationship to leave that relationship if the victim is judged to have limited psychological competence because of the severity of the circumstances. Whether it is ethically justifiable to require one to leave or to deny treatment should they refuse to leave is questionable (Rosen, Matheson, Stith, McCollum, & Locke, 2003). Most ethical codes admonish the practitioner to discontinue therapy when benefit appears to have ended. As an interpretation of Kidder's rule-based approach to decision making, a decision to deny therapy unless the victim leaves the relationship may appear justified. By contrast, demanding that a client relocate from a residence or else be denied therapy could be interpreted as abandonment since the potential for benefit in future therapy efforts may be jeopardized. Forcing someone to leave can also amount to an overt violation of the right to autonomy. If an initial effort is unsuccessful, the therapist might better maintain a position of respect for autonomous decision making (James, 2008). In discussing wives whose marriages involve domestic violence, Wolf-Smith and LaRossa (1992) asserted, "Respecting the choices that women make is an integral part of the counseling/therapeutic process. Victims must always know that there are people ready and willing to listen to them and assist them" (p. 329). Huston (1984) proposed that a therapist then should adopt more of a "maternalistic" treatment stance:

> Maternalism as the recommended treatment approach for battered women can be defined as offering a nurturing, directive stance at early stages of the client's development and an acceptance of more autonomy at later developmental stages. This approach recognizes that battered women as clients move through developmental stages of growth in objectively understanding their battering relationships. The women demonstrate different needs at different stages, and treatment must vary accordingly. . . . This stance is congruent with feminist treatment beliefs, because it acknowledges a deep respect for the autonomous functioning of the individual and yet recognizes the unique needs of specific populations and developmental tasks. (p. 831)

Entries in the feminist literature have pointed out that paternalism can be a debilitating mode of interaction with many women, reinforcing the predominant societal conditioning that made them passive and dependent (Goldner, 1999; Greenspun, 2000; Sue et al., 1998; Vatcher & Bogo, 2001). The maternalistic alternative espoused by Huston involves initial assertion but recognizes the potential need to patiently await developmental movement toward increased independence, positive self-worth, and autonomous action. For some therapists, such a decision may even represent a struggle between personal values and professional values on behalf of client's welfare. In this respect, the dilemma may be related to the Battle for Structure versus the Battle for Initiative. However, these dual battles are founded on an assumption of competence on the part of both client and therapist, an assumption that is questionable at best for victim of IPV.

To address this controversy, the use of ethical judgment by mental health professionals must be an integral part of treatment planning. Employing a guiding concept of neutrality has much to offer from an ethical standpoint. It ensures that all family members are treated as self-reliant, responsible individuals whose autonomy is recognized and respected (Willbach, 1989). However, Willbach also asserted that ethically aware marriage and family therapists actively

ize their perception of who is right and who is wrong in a family in which domestic violence resent. In doing, so he noted,

> An ethically aware approach to psychotherapy points to the flexible utilization of different techniques and modalities. Because family therapy developed in opposition to a tradition of individual therapy, the limits of its appropriate use have rarely been explored, as if to do so would run the danger of conceding valuable ground to the enemy. In fact, when a potentially actively violent abuser and the abused person are in the same family, family therapy may be generally contraindicated. (p. 50)

It is valuable to recognize that Willbach employs the qualifying term *may* in considering ntraindications for family therapy in cases of IPV. Family therapy certainly has a function in e treatment of such circumstances. Willbach affirmed this function, though with due consideration given to four interrelated clinical positions as a means of ensuring ethical practice:

1. The overt goal of therapy should be the complete cessation of intrafamily violence whenever it is present.
2. When intrafamily violence is the therapeutic focus, neutrality should not be a primary therapeutic procedure.
3. Therapists should use their ethical judgment in asserting individual responsibility for violent behavior.
4. Family therapy is contraindicated unless the violent family member is able to contract for nonviolence (i.e., formally agree not to use violence).

From this listing, we can identify specific stipulations for ethical care. For example, among the behaviors that can contribute to harm, marriage and family therapists must be especially sensitive to eliminating violence. Any therapeutic relationship that fails to stipulate a contingency of no violence would violate foundational ethical principles. Similarly, such a stipulation clearly reflects a nonneutral stance of by a therapist. Violence signals a breakdown in the very bedrock of family life, a family's willingness to take responsibility for the safety of its members, cautioned Mathias (1986), who quoted family therapist Betty Carter's admonishment, "To stop domestic violence you must intervene in the system in a dramatic way. . . . Putting the abuser in jail may not be therapy, but data shows it gets his attention and stops the violence" (p. 27). In this way, advocacy rather than neutrality serves to equalize interactions between partners. According to Bograd (1986), cases of IPV demand that marriage and family therapists "take unapologetically value-laden stands" (p. 47). He further stated,

> Most family therapy training discourages us from advocating for just one member of a couple. . . . But when there is violence, what is good for the system is often not good for the more victimized partner. For such couples, the most crucial intervention may be giving a strong, unequivocal message about who is responsible for the violence. (p. 47)

Clinical evidence suggests that abusive men require strong external pressures as motivation to seek treatment (Bergen & Bukovic, 2006; M. P. Johnson & Leone, 2005). The threat by their partner to leave or the partner's actually leaving has been viewed as the most effective pressure in such cases. Stith et al. (2004) described an approach that excluded the use of couple therapy. In a situation of power dominance by one partner over another, a model founded on

equitable opportunity to change and request changes is unsound (Phiri-Alleman & Alleman, 2008; Yoshika & Choi, 2005). In instances in which partners want to remain together, however, interventions that promote safety, reeducation, and support are vital. Following a brief respite of separation, these authors emphasized the use of multicouple therapy to accomplish these ends, noting significant reductions in aggression. In this approach, the context of violence can be considered among group members as well as individual couples in a way that avoids a linear view while promoting accountability and opportunity for more equitable change.

These and other alternative methods are important considerations for marriage and family therapists who encounter circumstances of IPV. Additionally, actions uninformed by cultural considerations are actions of simplicity and naïveté that can exacerbate an explosive and disorienting circumstance for a victim. A decision to imbalance a stable though harmful relationship by promoting safety for the victim is not an end but rather a step in the therapy process. In such instances, the therapist may have to assume an advocate role and relinquish the opportunity to return to a therapist role based on the perpetrator's perception of triangulation. However, therapists who exchange neutrality for protection can have some assurances that subsequent interventions may be successful with other practitioners should therapy be reinitiated. Above all, therapists are reminded of the necessity of promoting client welfare while being guided by their professional values and exerting their expert power in interactions with clients and others involved in the ecology of therapy.

REFLECTION 6–4

What are your conclusions about the example of IPV? Do you agree with ethical concerns emphasized in the example? What was overlooked? Would the approaches to decision making inform you if you were the therapist? Do the proposed discretionary actions coincide with your professional worldview? If not, how would you approach this matter differently?

Summary

In this chapter, we have attempted to present a thorough examination of a significant and complex ethical dilemma faced by many marriage and family therapists. In attempting to address the multiple ethical concerns discussed in the initial chapters of this text, we have presented a discussion of the considerations in a circumstance of IPV.

The struggles of addressing personal values and appropriate ethical actions are difficult and even isolating for marriage and family therapists. In instances such as IPV, we urge review of relevant professional literature, assessment of ethical and legal precedents, and consultation with colleagues or supervisors. However, we strongly support the contention of Pope and Vasquez (1998) that therapists must ultimately choose a course of action that reflects cognizance of human suffering.

We now move to Chapters 7 and 8, where we offer a review of significant contemporary ethical issues faced by marriage and family therapists. As you consider these issues, we suggest that you return to the framework used in this chapter as a way to consider multicultural contexts, practice traditions, and decision-making options to address ethical issues. Our hope is that the example of IPV can promote choices and actions on your part that demonstrate value-sensitive care within the ecology of therapy.