Issues in Domestic Violence: Legal and Ethical Issues

Introduction

Case Vignettes

Carrie is a 38-year-old mother of two preteen children. She has been dating Jack for the past year. When they initially met, she felt that she had finally met the man of her dreams, but now it seems like a constant nightmare. Shortly after the start of the relationship, Jack became physically abusive. Her children have recently witnessed the violence, and her youngest has urged her to call the police. Carrie is fearful of police involvement, however, many of the fears centering around whether her children will be removed from the household.

Domestic violence is a pattern of coercive tactics perpetrated by one person against an intimate partner, with the goal of establishing and maintaining power and control. Domestic violence includes physical, psychological, sexual, economic, and emotional abuse. Domestic violence occurs across a spectrum of intimate relationships, including married couples, dating couples, couples who live together, people with children in common, same-sex partners, people who were formerly in a relationship with the person abusing them, and teen dating relationships.

Carrie’s story is not an isolated one. Given the prevalence of intimate partner violence, mental health clinicians will likely encounter a survivor in his or her practice. An estimated 5.3 million cases of intimate partner violence are reported each year (CDC, 2003). These incidents result in 486,000 emergency room visits and 18.5 million therapy sessions each year (CDC, 2003). While these numbers may seem high, and they certainly are, they are gross underestimates. According to 2006 Bureau of Justice statistics, less than one-fifth of victims reporting an injury from intimate partner violence sought medical treatment following the injury. Similarly, many domestic violence victims do not report incidents of abuse to law enforcement due to perceived risks of removal of children, dual arrest policies, homelessness, embarrassment or deportation.

Mental health clinicians may be placed in the role of helping to facilitate such reports. They may serve as a lifeline for patients, providing them with information on resources, advocacy and helping them negotiate the justice system. While clinicians cannot be experts on all fronts, it is important to have an understanding of the systems in which victims may need to operate. Additionally it is critical that clinicians be aware of their ethical obligations to domestic violence victims and their children.

This is not always easy. According to the American Psychological Association Task Force on Violence and the Family, the legal system is fraught with numerous problems. The report states: “Most victims of family violence will have
some contact with the legal system that is not well designed to handle such cases. In addition, inequities in the application of the law, racial and class bias, and inadequate investigations have harmed rather than helped many families. The low priority given to funding for implementation of child protection laws results in a legal system that frequently fails to work. Many battered women find themselves in dangerous positions because the courts often do not give credence or sufficient weight to a history of partner abuse in making decisions about child custody and visitation. Racial bias often influences the court's decision about whether to order treatment or to imprison offenders.

It is important that mental health professionals find ways to negotiate sometimes faulty systems. The first step is in understanding needs of the victim and clinicians’ professional obligations.

This course will provide an overview of risks, a discussion of why survivors are reluctant to disclose abuse, the legal resources available to clients and ethical obligations. It will also contain an appendix with helpful information, including a summary of state laws on mandatory arrest and a sample safety plan.

The terms “domestic violence” and “intimate partner violence” will be used interchangeably in this training material.

Upon completion of this course participants will:

Objectives

1. Discuss the scope of the problem, including intimate partner homicide, lethality assessment and nonfatal injuries
2. Discuss reasons why victims often fail to report intimate partner violence
3. Define “mandatory arrest” and “dual arrest” and describe the implications of each
4. Describe issues related to empowerment and advocacy
5. Discuss navigating the various systems related to domestic violence
6. Discuss ethical and legal issues related to domestic violence

Scope of the Problem

Prior to looking at the legal aspects of intimate partner violence, it is helpful to look at the history in the impact of domestic violence and its connection to the criminal justice system. While domestic violence is certainly not new, it is only recently that it has been considered a violation of the law. Prior to about the 1970s (and sometimes even currently), domestic violence was seen as a "normal" part of marriage or intimate relationships.
A significant factor in the why the criminal justice system has undergone reforms is how dangerous domestic violence is. The statistics cited in the introduction tell only part of the story. Domestic violence presents a number of concerns related to safety. Mental health providers should be careful not to minimize safety concerns, and assessment of safety and risks should be an ongoing component of therapy.

**Intimate Partner Homicide**

April 4, 2011 – Orlando, Florida. Police arrested a man they said killed two people at an Orlando apartment complex on Sunday night. Officers said 45-year-old Eligio Isalgue shot his estranged wife and her new boyfriend. Isalgue was arrested in the complex’s parking lot. Investigators said they found a gun inside the apartment. Two other people, including Isalgue’s 13-year-old daughter, were in the apartment. The others were not injured. Investigators said the husband and wife had not lived together for about two months.

Intimate partner homicide is defined as a homicide perpetrated against a current or former spouse, cohabitant, or romantic partner by his or her intimate partner. Here is a summary of some key findings (Catalano et al., 2009):

- In 2007 intimate partners committed 14% of all homicides in the U.S. The total estimated number of intimate partner homicide victims was 2,340, including 1,640 females and 700 males.

- Females were killed by intimate partners at twice the rate of males. Females are generally murdered by people they know. In 64% of female homicide cases, females were killed by a family member or intimate partner. 24% of female homicide victims were killed by a spouse or ex-spouse; 21% were killed by a boyfriend or girlfriend; and 19% by another family member.

- Men were more likely than women to be killed by strangers. Among male homicide victims, 16% were murdered by a family member or intimate partner. Of male homicide victims, 2% were killed by a spouse or ex-spouse and 3% were killed by a girlfriend or boyfriend. Over half (54%) were killed by others they knew, and 29% were killed by strangers.

Prior domestic violence is a strong risk factor for intimate partner homicide. Campbell and Glass (2009), who conducted a study of female victims of intimate partner homicide, found that approximately 80% of women had been a victim of physical and/or sexual intimate partner violence or stalking prior to their murder and 42% were seen in the healthcare system the year before they were killed. While the women themselves are not always good at assessing their own risk, Campbell and Glass state that healthcare professionals, including those in the mental health fields, can be a resource for identifying women who are at risk.
Currently about 20 states have fatality review teams, which comprehensively look at each death. These teams promote prevention and track patterns of homicides and suicides resulting from intimate partner homicide.

Collectively these review teams have found some common warning signs of intimate partner homicide. These include (Campbell et al., 2003):

- A prior history of domestic violence and injuries
- Attempts to break away from the abusive partner (such as a protective order, pending divorce, or moving out of the house
- Stalking or threatening behaviors
- Previous police involvement
- History of mental illness
- History of drug or alcohol abuse (abusive partner or victim)

**Assessing Safety**

Safety planning is an important component of treatment. Experts on trauma work such as Herman (1997) and Bloom (1997) state that creating safety for trauma survivors is key to recovery. With survivors of domestic violence, this often involves assessing lethality and developing a safety plan. This training material will discuss safety planning later in this chapter. Mental health professionals can use the warning signs of intimate partner homicide in their safety assessment. Additionally safety assessments involve asking clients about:

- Increases in frequency of violence
- Means of violence (physical violence, presence of guns)
- Threats of violence
- Presence of a child that is not the abuser’s
- Control
- Threats of suicide
- Stalking or spying behavior

**Other Losses**

**Case Vignette**

A case making breaking news in New York is that of the death of Mary Kennedy, who committed suicide. Her death came on the heels of husband Bobby Kennedy filing for divorce. Bobby Kennedy alleges that he was the victim of domestic violence. Mary’s family alleges that she was a victim.

In addition to homicide of victims of intimate partner violence, there are also other losses. Suicide attempts/completed suicide is another loss associated with
domestic violence. Suicide.org estimates one out of every four women who are the victims of domestic violence attempt suicide.

Non-fatal Injuries

While the discussion of intimate partner homicide provides a frightening picture, in terms of sheer numbers, the number of men and women who suffer non-fatal injuries is significantly higher. In 2008 females age 12 or older experienced about 552,000 nonfatal violent victimizations (rape/sexual assault, robbery, or aggravated or simple assault) by an intimate partner (a current or former spouse, boyfriend or girlfriend). In the same year, men experienced 101,000 nonfatal violent victimizations by an intimate partner. About two-thirds of reported victimizations occur at home. After the incident, less than one-fifth of victims seek medical care (Catalano et al., 2009).

Reporting Intimate Partner Violence

Many victims of domestic violence fail to report abuse to the police. Research has show gender differences in reporting rates, as well as some of the reasons that victims choose not to make a police report. Males victims of domestic abuse are actually more likely to report violent conflicts. In 2008, 72% of the intimate partner violence against males and 49% of the intimate partner violence against females was reported to police. Stalking victimization was equally likely to be reported to police whether the victim was male or female. Thirty-seven percent of male and 41% of female victimizations were reported to the police by the victim or another person aware of the crime (Catalano et al., 2009).

A recent study from the Bureau of Justice statistics found that the major reasons for not reporting abuse to police were: fear of reprisal (15%), belief that police cannot help (6%), and a feeling that violence is “private” (28%). Additionally many victims of intimate partner violence are extremely isolated from sources of support, and lack the support networks to leave abusive environments. They may be faced with the prospect of homelessness or family separation.

This distrust of the legal system also extends to healthcare professionals. This may be particularly true when children are involved or children witness or are victims of family violence. One source of controversy are “failure to protect” statutes. These statutes may be enforced if victims choose to remain with abusers as they place children in harm’s way. In some states, children can be removed from the family in this situation.

Many victims of domestic violence also hide the abuse from health care providers. What is unfortunate is that by doing so they may be cutting themselves off from potential resources and sources of help. It is important that mental health professionals be aware of signs of domestic violence and include questions
about the possibility of domestic violence in their screenings. It is important to ask these questions outside the presence of the potentially abusive partner.

**Mandatory and Dual Arrest Policies**

In understanding domestic violence and the law it is important to understand the legal context of domestic violence. The U.S. Department of Justice defines domestic abuse or violence as, "a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner."

Since the 1970s, many states have implemented so called "warrantless arrest policies" in an effort to deter domestic violence. While these laws have been helpful in increasing rates of arrest, prosecution, and conviction of perpetrators of domestic violence (National Research Council, 2004), they have led to some problems. State laws vary with regard to circumstances under which warrantless arrests can be made. For example, some stipulate that arrests can be made in cases of felonies, within a certain number of hours of the incident, and/or if the persons involved are married, blood-related, living together or have a child together. A listing of these policies can be found in the appendix of this training material.

*Mandatory arrest policies* mean the police officers are required by law to make arrests based on probable cause that domestic violence was committed. Some states that have mandatory arrest provisions include: Alaska, Arizona, Colorado, Connecticut, Iowa, Kansas, Louisiana, and the District of Columbia. *Preferred arrest policies* are less strict; they encourage but do not mandate arrest as the favored action when probable cause exists. States with preferred arrest provisions include: Arkansas, California, Massachusetts, Montana, North Dakota and Tennessee. *Discretionary arrest Policies* allow greatest leniency when confronted with domestic violence. The statutes stipulate that the officer "may" arrest under certain circumstances where probable cause is evident. Those states with discretionary arrest provisions include: Michigan, Minnesota, Nebraska, New Hampshire, New Mexico, North Carolina, Oklahoma, Pennsylvania, Texas, Vermont, West Virginia and Wyoming.

With these policies, an important (but subjective) determination is the idea of "primary aggressor." Responding officers often have to sort out varying stories of what occurred. In situations where there is a lack of clarity, officers make a *dual arrest*. In this instance, both victim and perpetrator are arrested, and the court makes the determination. These policies have come under fire by domestic violence advocates, such as Eleanor Pence, developer of the Duluth Model of intervention. She states that contemporary domestic violence intervention, far too often, is "one-size-fits-all," and can allow some chronic violent abusers to avoid
proper punitive sanctions for their long-term violent behavior.

Buel and Hirst (2009) believe that healthcare professionals can be instrumental in helping victims to advocate for themselves when threatened with dual arrest. They can serve as “translators” to help victims of domestic violence to voice what occurred. While this role is an important one, the overall feeling is that dual arrest policies can be detrimental to victims of intimate partner abuse.

Advocacy

As Buel and Hirst’s (2009) comments suggest, one role that mental health professionals can play in working with domestic violence is advocacy. Victims of intimate partner violence generally feel disempowered and overwhelmed by the many systems and legalities associated with trauma. They may be struggling to create physical and emotional safety.

What is empowerment? Wilson and Martin (2006) define the word “empower” as “increasing the control people have over their lives.” They include components of feeling powerful, competent and worthy of self-esteem. These authors also state that there needs to be a modification of the structural conditions in order to reallocate power.

The Advocacy Wheel for domestic violence (The Missouri Coalition Against Domestic Violence, n.d.) follows. Based on the Duluth Wheels, this graphic provides a schema that describes the role of the clinician-advocate. The central goal of the wheel is to help promote empowerment for victims of domestic violence.
While clinicians will have differing roles with regard to advocacy, this wheel is broad enough to cover many of these. A synopsis and explanation of each follows:

Confidentiality: As a first step, the clinician must establish confidentiality. Discussing the possibility of victimization must occur in private. A victim of domestic abuse will not typically disclose a history of violence in the presence of her perpetrator or other family members. If she discloses the violence in his presence, it is likely she will suffer retaliation. When there may be limits to confidentiality (discussion will follow), these must be verbalized at the outset. It is helpful to emphasize that the goal of any intervention is providing help.

One area that can be particularly tricky is balancing the role of advocating from a victim of abuse and the mandate to report child abuse.

Case Vignette
Maureen Quinto, a licensed social worker, is employed at a community mental health center. She completed an intake with
Mary, a new client seeking help for depression. Mary reported to Maureen that her husband would often beat her and the children. Maureen complied with agency procedures, and reported the child abuse. She received a distraught and angry phone call from Mary, stating that her children had been removed from the house.

Case Vignette
Trudi Hayes, a licensed social worker, is employed at a community mental health center. She meets with a new client, Maribeth. Prior to the intake, she discusses confidentiality, including the limits around child abuse reporting. Maribeth states that she is frightened to tell her what has been happening at home because “I don’t want to lose my kids.” Trudi explains that if a parent initiates a call to Child Protective Services, they are less likely to take the children, stressing that there are resources that can help her. She does not make any guarantees. Maribeth tearfully describes how her husband Tom beats her and the kids. Together they call Child Protective Services, who supports Maribeth in her efforts to take the children to a domestic violence shelter.

These two cases illustrate the importance of managing confidentiality issues in a way that is sensitive and also affirms the role of the non-abusing parent as an integral role.

Validation: Validating that violence perpetrated against the victim is true. Victims of domestic violence may be fearful that they will not be believed if they report abuse. In many households where there is domestic violence, and abusive partner can look very “normal” or be considered by others to be an “upstanding citizen.”

Acknowledge the Injustice: Victims of domestic violence often feel that abuse is their fault. Be aware of blaming statements and respond appropriately. There is often a great deal of self-doubt and blame.

Autonomy: Empowering advocacy is based on the core belief that victims of domestic violence have the right to control their own lives. In the process of victimization, control has been taken away from them. Clinicians should provide victims with autonomy by guiding, but allowing victims to make their own decisions.

Safety Planning: What are the victim’s options? Safety is critical. According to the American Psychological Task Force on Violence and the Family (1996) (as summarized by Wilson & Martin, 2006) the following strategies will help ensure safety:
• Calling the police
• Calling a shelter
• Leaving the home or scene
• Superficially complying with the abuser’s demands
• Talking to friends
• Hiding
• Avoiding the abuser
• Seeking professional help
• Avoiding conflict and keeping the peace

It is also important to remember that the victim is often the ultimate expert on how an abuser will respond. For example, leaving the house may not be an option because it will further incense the abuser. According to Wilson and Martin (2006), two important questions to ask are: “What are some of the cues or behaviors that are present before a violent incident occurs?” and “What have you done in the past to successfully protect yourself and your children.”

Clinicians can also use the sample safety plan (contained in the appendix), a detailed roadmap for victims. It is important to discuss safety procedures, and review them frequently.

Promote Access To Community Services: Know the resources in your community. If you are able to do so, provide victims with a written list that they can refer to.

Navigating the Systems

A key component in working with domestic victims is in helping them to navigate the various systems they encounter. In addition to the mental health system, some of these systems include: legal, medical, social service, and child protective. When making a referral to any of these systems it is helpful to provide victims with a sense of what they can expect.

While each state varies with regard to the systems in place to prevent and respond to domestic violence, there are some similar agencies that many states have in common. The following is a summary of some of these systems. It is important to know the resources in your home state.

Offices for the Prevention of Domestic Violence

These systems support local and state domestic violence efforts. While many of their efforts have to do with grants and funding, they can be a resource for
learning about availability of domestic violence training and a clearinghouse of other services.

**Offices of Victim Services**

Many states have offices of Victims Services. These can be invaluable in supporting victims. Victims Services compensates victims of crime for unreimbursed out-of-pocket expenses, which can include expenses for mental health counseling (including counseling for children and relatives). These systems provide funding to victims of spousal abuse, sexual assault and child abuse. In some states these program includes other victims of violent crime.

In addition to victim compensation, most offices of victim services provide advocates help victims of violent crime by notifying them of their rights and by providing information and assistance. These advocates:

- Provide information to the victim about the criminal case and criminal justice system
- Act as a liaison between victims and court personnel
- Escort victims and their family members to court proceedings
- Advocate for victims during court proceedings
- Provide victims with social service referrals
- Assist victims and their family members in preparing and delivering a victim impact statement

**Criminal And Civil Courts**

This system is the legal arm of domestic violence. Many states have dedicated domestic violence courts that act on criminal complaints pertaining to domestic violence. This ensures consistent responses to domestic violence. Domestic violence is no longer treated as a simple battery. Consequently, our system imposes enhanced and specialized sentences for these offenses.

One important function of civil courts involves the issuance of protective orders. An order of protection (also called a restraining order) is an official document that outlines provisions that limit contact between an abusive partner and the victim. There are generally two types of protective orders: protection from abuse (PFA) and protection from harassment (PFH). According to Buel & Hirst (2009) the orders may include provisions that:

- Prohibit future abuse against victims and any children in the home
- Maintain a 100-yard distance from the victim, home, workplace or other appropriate location
- Refrain from contacting the victim in any way
- Determine who may stay in residence
• Pay compensation for damages
• Award custody of the child
• Require supervised visitation
• Enforce payment of spousal and child support
• Prohibit purchase of a gun and relinquishment of guns during the enforcement of the protective order
• Require appropriate counseling or treatment for the abusive partner

While the process for filing a protective order will vary from state to state, there are some similarities. In most places, once appropriate paperwork is completed, a temporary (“ex parte”) protective order is issued. This order keeps the abusive partner away from the victim for a specified period of days (usually about 5-7) until a formal hearing is held. At the hearing, the judge decides if the protection order will be canceled or continued.

While it is not mandatory that the victim bring any “proof” with her to court, it is generally helpful. Proof of abuse or harassment may include:

• Photographs of injuries (and if possible the person who took the photographs)
• Threatening notes, email, phone messages.
• A witness who saw or overheard the abuse, even though in some courts only the parties are allowed to testify.

A victim advocate may be helpful to provide additional support.

Once a protection order has been issued, its effectiveness in ensuring the continuing safety of the protected person depends in large measure on the enforcement of that order. Enforcement must occur smoothly and routinely in order to work as a deterrent to continued domestic violence. States and municipalities establish rules around the enforcement of protective orders. The Federal Violence Against Women Act (VAWA) makes protection orders enforceable across state lines. If a victim believes that an order of protection has been violated, he or she should call police immediately. In many states, violators of protective orders are immediately arrested and jailed.

Family Courts

Intimate partner violence is a common issue in custody, visitation, and divorce cases. Family courts are often called upon to assess the impact of family violence with regard to these types of court cases. Since custody and visitation cases often involve mental health issues, expert testimony from mental health providers may be required.

Departments of Health
These systems include direct medical services. Rape crisis centers are also housed within departments of health. These systems generally also provide direct crisis counseling.

**Child Protective Services (CPS)**

While most clinicians know the term “child protective services”, it is often not until a client is involved in this system that CPS functions are truly understood. Many women who have been abused by an intimate partner are also involved with CPS, and by extension, treating clinicians will be involved as well. In defining CPS, the Family Violence Prevention Fund states: “The child protection system is a bureaucratic government institution responsible for ensuring that various laws, regulations and policies regarding the protection of children are enforced.”

While state laws vary with regard to what is reportable to CPS, in many states clinicians are mandated to report to CPS any reasonable suspicion of child abuse or neglect.

Most women fear the possibility of a report being filed with CPS. While there are cases in which children are removed from an abusive household, more often efforts are made to keep children with a non-abusing parent. This may mean that a parent is referred to a shelter or short-term housing. CPS often also runs support groups and can refer women to additional resources. The following types of services are available:

*Family support services* are community-based services that assist and support parents in their role as caregivers. Family support services promote parental competence and healthy child development by helping parents enhance their strengths and resolve problems that can lead to child maltreatment, developmental delays, and family disruption.

*Family preservation services* are short-term, family-focused, and community-based services designed to help families cope with significant stresses or problems that interfere with their ability to nurture their children. The goal of family preservation services is to maintain children with their families or to reunify them, whenever it can be done safely.

**Ethical Considerations: Confidentiality**

*Dr. Markin is working with Patricia, a registered nurse, who has recently separated from her husband Gerald. Patricia has two daughters, ages 8 and 10. Gerald sees his daughters on weekends. Gerald has been abusive to Patricia in the past, but she denies any current incidents. Patricia has worked hard to*
increase her autonomy, and has stated that she will not condone any type of abuse to herself or her daughters. Following the separation, Patricia purchased a handgun and has taken shooting lessons. Patricia phones Dr. Markin for an emergency session. She tells Dr. Markin that her older daughter came home from a weekend visit with bruises, stating that her father had hit her because of her “foul mouth.” Patricia is incensed, stating that she plans to “kill that son of a bitch.”

What are Dr. Markin’s obligations here? Should she report Gerald to child protective services? Does she have a duty to warn Gerald about the threat to his safety?

Mental health professionals are confronted with a wide range of ethical and legal issues concerning their treatment of victims of domestic violence. As the case above illustrates, many ethical issues arise as a result of balancing the roles of therapist, advocate, and mandated reporter. Mental health functions frequently intersect with other disciplines, which can lead to conflicts in maintaining confidentiality. For example, a common issue that arises in treatment of domestic violence victims is the need to interact with the various systems discussed in this material, such as the criminal justice system, child protective services, etc. The case vignette provided an example of potential disclosure of confidential therapy discussions to child protective services. Questions may arise regarding whether clinicians can maintain the confidentiality of patient information or whether they must comply with police or court requests for access to health records or reports. Another common issue is whether mental health professionals should breach confidentiality in relation to patients they consider at risk of harming themselves or others. This section will discuss several of these issues. It is important, however, to be aware of the specific guidelines of the state in which you practice.

To begin, let’s look at the obligation to maintain confidentiality, a standard shared by all professional codes. An example of this guideline is contained in National Association of Social Workers (NASW) standard 1.07, which states: “Social workers should respect clients’ right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.”

That does not mean, however, that social worker, psychologists, and counselors cannot share confidential information. When an appropriate authorization is in place, and clients consent to sharing information, this is allowable. Examples that may apply to domestic violence cases are: interacting on the patient’s behalf to obtain housing, sharing information with courts to support an order of protection, or coordinating with a child’s school teacher or counselor.
Compelling Reasons to Break Confidentiality

Professional codes of ethics allows disclosure of confidential information when there are “compelling professional reasons.” These reasons include “serious, foreseeable, and imminent harm to a client or other identifiable person.” This is a broad dictate, and can include (but is certainly not limited to) harm to a minor child, harm to an elder, harm to oneself, or harm to others. Should a clinician be required to break confidentiality, he or she should disclose “the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed” and when possible, inform clients of the disclosure in advance.

While the confidentiality standards discussed in the previous paragraph are ethical mandates, a closely related legal function is the clinician’s role as a mandated reporter. Simply put, being a mandated reporter means that an individual is required to report suspected cases of abuse. All states have passed some form of mandatory child abuse and neglect reporting law in order to qualify for funding under the Child Abuse Prevention and Treatment Act (CAPTA). In addition to child abuse reporting laws, many states also have laws pertaining to mandatory reporting of elder abuse (for more about older adults and domestic violence please see “Issues in Domestic Violence: Special Populations.”) The laws apply to mental health providers working both in private practice and institutional settings.

One common question is how certain about clinicians need to be in order to make a report of abuse. Although this is something that each clinician needs to decide for his or herself, Pass (2007) observes that if a clinician witnesses only behavioral symptoms of child abuse (e.g., sudden changes in behavior or school performance, hypervigilance, concentration problems) it is best for the clinician to document their observations and continue to assess the situation. When a professional observes physical symptoms (e.g., bruises or other marks) it is best to consult with a colleague and also to speak with a parent or guardian. When a clinician notices a combination of physical and behavioral symptoms, however, an immediate report is indicated. On a therapeutic level it is important to consider the potential consequences of reporting, and thoroughly assess the situation. There is no timeframe; a 2-3 week assessment is ok if the child is not in immediate danger.

In addition to issues regarding suspected child abuse, clinicians are ethically bound to disclose information in situations in which they believe a client will harm themselves or another identifiable person. With the link between domestic violence and suicidal thoughts/attempts (see Devries et al., 2011) it is important to keep in mind that a clinician may need to seek help for a client, even if it means breaking confidentiality. Additionally they may be compelled to seek help for an intended victim, even if that victim is an abusive partner. The treating
professional’s duty to warn is discussed in a subsequent section.

Confidentiality and Privilege

Case Vignette

Carla Varnis, a clinical social worker, is working with Pamela. Pamela has been a victim of domestic abuse. Carla receives subpoena for medical records from Pamela’s husband’s attorney. Pamela’s husband has filed for custody, stating that Pamela is “crazy” and “unfit to be a parent.” Carla recognizes that her therapy notes likely do have some information about Pamela’s past mental health history that could be prejudicial. What should she do?

As this case illustrates, the intersection of the court system and mental health system can prove to be challenging. In some cases, such as when a clinician is providing information that a client has requested that a court representative receive, it is simple. For example, if a client requests that her own lawyer receive a summary of therapy sessions, such information can be provided by having the client sign a release form authorizing this disclosure. This is covered by NASW ethical standard 1.07b “Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client” and by similar standards with the other professions. It is still important, however, to explain to the client the potential consequences of the disclosure prior to releasing the records to a third party. NASW ethical standard 1.07d states “Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made.” The standard goes on to clarify that clinicians should still educate the client about the potential effects of disclosures “on the basis of a legal requirement or client consent.” While other ethical codes (such as the APA code) are not as specific about the need to provide psychoeducation, it is good clinical practice.

A question that frequently arises is the distinction between confidentiality, an ethical and legal requirement, and privilege, a legal term. Psychotherapists have an ethical and legal requirement to maintain the confidentiality of disclosures made by clients during the course of treatment.

In the case of the vignette presented at the outset of this section, in which an attorney subpoenas treatment records a clear conflict exists for the clinician. The therapist in the vignette, Carla, has several duties to Gloria, one of which is to maintain the confidentiality of their communications. In order to do so, Carla must assert psychotherapist-patient privilege. By asserting privilege, Carla is communicating to the court that she recognizes her duty to respond to the subpoena asking her to provide information to the Court (which is a legal obligation), but that she has a competing duty to the patient to keep her therapy disclosures confidential. Further by invoking privilege Carla is asserting the belief that her duty to maintain patient confidentiality outweighs the duty to provide
information that could be used as evidence. Asserting privilege acts as a request to the court to be exempted from the duty to provide this confidential information (Clinical Lawyer, n.d.)."

While the opposing lawyer can continue to fight to see Gloria’s records, most courts err on the side of privilege. It is helpful to speak to legal experts from the state licensing board that governs your profession.

**Treating Professional’s Duty to Warn**

Another ethical issue is the treating professional’s duty to warn. Let’s return now to the case vignette that introduced this section:

*Dr. Markin is working with Patricia, a registered nurse, who has recently separated from her husband Gerald. Patricia has two daughters, ages 8 and 10. Gerald sees his daughters on weekends. Gerald has been abusive to Patricia in the past, but she denies any current incidents. Patricia has worked hard to increase her autonomy, and has stated that she will not condone any type of abuse to herself or her daughters. Following the separation, Patricia purchased a handgun and has taken shooting lessons. Patricia phones Dr. Markin for an emergency session. She tells Dr. Markin that her older daughter came home from a weekend visit with bruises, stating that her father had hit her because of her “foul mouth.” Patricia is incensed, stating that she plans to “kill that son of a bitch.”*

What are Dr. Markin’s obligations here? Should she report Gerald to child protective services? Does she have a duty to warn Gerald about the threat to his safety?

There are clearly a number of issues involved in this case, including therapeutic, ethical and legal concerns. Let’s take each of these duties separately. From a therapeutic standpoint, Dr. Markin has a duty to provide a safe environment in which Patricia can work through her feelings about her relationship with Gerald. Such safety is especially critical to allow victims of domestic violence to heal from their traumas and to move forward with their lives. According to the Advocacy Wheel depicted earlier it is critical to respect confidentiality, promote safety and validate the victim’s experiences. Given these important concerns, it is important that any decision that would involve breaking confidentiality be fully considered.

Ethically, Dr. Markin could, if he feels it is indicated, make a disclosure based on the limited details of the case. According to APA Ethical Standard 4.05B Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (3) protect the client/patient, psychologist, or others from harm. While Dr. Markin could disclose information for the reason of protecting Gerald, it would clearly come into conflict with his ability to act in a therapeutic manner.
Tarasoff v. Regents of the University of California (1976) is the case that established the duty to warn in California and iterations of the “duty to warn/duty to protect” laws have been passed in most states across the country. The idea behind these laws is that by accepting responsibility for the care of a client in need of mental health treatment, the clinicians may owe a duty to protect third parties from harm threatened by the client. The Tarasoff ruling states: “When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger” (Tarasoff, 1976, p. 340).

What makes the question of what Dr. Markin should do even more confusing is that there are state variations in duty to warn requirements. The following categories apply (NASW):

**Mandatory Duty to Warn.** Some states establish a mandatory duty to warn. These are: Arizona, California, Colorado, Delaware, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, Ohio, Tennessee, Utah, Virginia, and Washington. A number of these states also have court decisions that have interpreted the duty to warn laws.

**“Permissive” Standard.** Some states give permission in state statutes for therapists to warn of serious threats. These states are: Alaska, Arkansas, District of Columbia, Florida, Hawaii, Iowa, Mississippi, Missouri, New Mexico, New York, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Virgin Islands, West Virginia, and Wyoming. In some states, such as Texas, the permission to warn is limited to notifying medical or law enforcement personnel, not the threatened person or persons.

**No Statutory Standard.** A third set of states does not provide any statutory language addressing the duty to warn, but some of these have implemented the duty through court decisions. Connecticut, Pennsylvania, Vermont and Wisconsin do not have statutory provisions, but have established a duty to warn through court decisions. States that are silent as to the social worker’s duty to warn are Georgia, Kansas, Maine, Nevada, North Dakota, and Puerto Rico.
While these variations make it hard to determine a one-size fits-all approach to what to do in the case study, there are some recommended standards for decision making. According to the NASW publication *Social Workers and State Duty to Warn Laws*, some of the key issues to review in a case involving a possible duty to warn are:

- Whether the client is the individual who represents a threat to self or others
- Who has disclosed the threat and under what circumstances
- How much time has passed since the threat was made
- Whether the client possesses the means and capacity to carry out the threat
- Whether the duty to warn has been established as a mandatory requirement in state law
- Whether the threat of harm is to a specific individual or represents a general threat to the public at large
- Whether the criteria for involuntary commitment may apply
- Whether the state permits disclosure of a threat even if it is not mandatory
- Who needs to be warned to effectively discharge the duty to warn (e.g. Law enforcement, the intended target, the department of motor vehicles, a treating physician, a responsible family member).

Sample conversation with Patricia (state variations will occur)

After allowing Patricia time to talk about feelings:

Dr. Markin: I am concerned about some things that you said earlier. You said that you wanted to “kill that son of a bitch.” Do you still feel that way?

Patricia: I don’t want to see my daughter being abused the same way I was.

Dr. Markin: That’s understandable. But meeting violence with violence is not the answer. If you went to prison, your daughters would have no one to care for them.

Patricia: I know that. I just feel so powerless.

Dr. Markin: I think that one thing that may help is to make a call together to Child Protective Services. They will help us to make sure that both you and the girls stay safe.
In this situation, Dr. Markin used his clinical judgment to diffuse a potentially dangerous situation. Had Patricia been less cooperative and he felt that a credible threat still existed, enlisting the support of the authorities may have been necessary.

Summary

This training material discussed many of the legal and ethical issues related to supporting victims of domestic abuse. While clinicians cannot be “experts” on all facets of domestic violence competent care is grounded in the ethics and standards of the profession. Mental Health professionals need to be aware of ethical and legal standards and they also need to develop and maintain the professional skills necessary to work with victims and families affected by domestic violence.
Appendix

Domestic Violence Safety Plan

Victims of domestic violence need to plan *in advance* for safety. The following considerations are important ones, and can be discussed in a therapy session.

**Things to think about and have ready:**

1. Important phone numbers. These may include hotlines, clergy, school contacts, friends and the local domestic violence resources and shelters.
2. Friends or neighbors that could seek help on your behalf. Ask them to call the police if they hear angry or violent noises. If you have children, teach them how to dial 911. Make up a code word that you can use when you need help.
3. Safe exit from home. Practice ways to get out quickly if need be.
4. Safer places within home. Think about places where victims can go to be away from the abuser.
5. Remove all weapons from the house if possible.
6. Even if clients are not open to the idea of leaving, it is still important to, have them consider where they could go. An “exit strategy” is also helpful. This strategy may involve a way to leave the house, such as walking the dog or going to the store. It is also helpful to have a bag of everyday items packed, but well hidden.
7. Encourage clients to go over their safety plan often.

**Other considerations:**

1. Have clients think of three or four places they could go if they leave home.
2. Have clients think about people who might help if they left. These may include people who could keep a bag for them, who could loan them money, or who could help with children. It is also important to make plans for pets.
3. Clients may consider getting a prepaid cell phone to pack in a bag.
4. Clients may consider opening a bank account or getting a credit card in their name only.
5. Clients should consider issues regarding children. There may be times when it is safer to leave without children.

**Things to take**

- [ ] Order of protection
- Money
- Keys to car, house, work
- Extra clothes
Medical

Important papers
Birth certificates
Social security cards
School and medical records
Bankbooks, credit cards
Driver's license
Car registration
Welfare identification
Passports, green cards, work permits
Lease/rental agreement
Pictures, jewelry, things that are meaningful
Items for children (toys, blankets, etc.)
## States with Mandatory Arrest Provisions

<table>
<thead>
<tr>
<th>State</th>
<th>Probable cause to believe that a crime of domestic violence was committed within past 12 hours.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>Probable cause to believe that a crime of domestic violence was committed within past 12 hours.</td>
</tr>
<tr>
<td>Arizona</td>
<td>Domestic violence involving infliction of physical injury or use/threatening use of a deadly weapon.</td>
</tr>
<tr>
<td>Colorado</td>
<td>Probable cause to believe a crime of domestic violence was committed.</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Speedy information that family violence was committed in jurisdiction.</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>Probable cause to believe that an intrafamily offense was committed that resulted in physical injury including pain or illness or caused or was intended to cause reasonable fear of imminent serious physical injury or death.</td>
</tr>
<tr>
<td>Iowa</td>
<td>Probable cause to believe that domestic abuse assault committed that resulted in bodily injury, or was committed with intent to inflict serious injury, or with use or display of a dangerous weapon.</td>
</tr>
<tr>
<td>Kansas</td>
<td>Probable cause to believe a crime has been committed.</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Reason to believe family or household member has been abused and (1) probable cause exists to believe that aggravated/second degree battery was committed or (2) aggravated or simple assault or simple battery committed and reasonable belief in impending danger to abused.</td>
</tr>
<tr>
<td>Maine</td>
<td>Probable cause to believe there has been a violation of aggravated assault statute between members of same family or household.</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Probable cause to believe that within 24 hours offender knowingly committed a misdemeanor act of domestic violence.</td>
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<tr>
<td>Missouri</td>
<td>Called to same address within 12 hours.</td>
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<tr>
<td>State</td>
<td>Probable cause to believe same offender has committed abuse or assault against same or other family/household member.</td>
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<td>---------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Nevada</td>
<td>Probable cause to believe that within 24 hours battery was committed.</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Probable cause to believe that domestic violence has occurred and either victim shows signs of injury or probable cause that a weapon was involved.</td>
</tr>
<tr>
<td>New York</td>
<td>Probable cause to believe a felony has been committed against a member of the same family or household or, unless victim requests otherwise, a misdemeanor family offense committed.</td>
</tr>
<tr>
<td>Ohio</td>
<td>Reasonable cause to believe that offender committed felonious assault.</td>
</tr>
<tr>
<td>Oregon</td>
<td>Probable cause to believe that a felonious assault or an assault resulting in injury occurred or action has placed another to reasonably fear imminent serious bodily injury or death.</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Probable cause to believe the following: felonious assault: assault resulting in injury: action was intended to cause fear of imminent serious bodily injury or death.</td>
</tr>
<tr>
<td>South Carolina</td>
<td>If physical injury is present and probable cause to believe person is committing or has freshly committed a misdemeanor/felony assault or battery.</td>
</tr>
<tr>
<td>South Dakota</td>
<td>Probable cause to believe that within previous 4 hours, there has been an aggravated assault, an assault resulting in bodily injury, or an attempt by physical menace to place in fear of imminent serious bodily injury.</td>
</tr>
<tr>
<td>Utah</td>
<td>Probable cause to believe that an act of domestic violence was committed and there will be continued violence or evidence perpetrator has recently caused serious bodily injury or used a dangerous weapon.</td>
</tr>
</tbody>
</table>
| Virginia      | Probable cause to believe assault or
<table>
<thead>
<tr>
<th>State</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Washington</td>
<td>Probable cause to believe a person 16 years or older within the previous 4 hours assaulted a family or household member and believes (1) felonious assault occurred, or (2) assault resulting in bodily injury occurred whether injury is visible or not, or (3) any physical action occurred which was intended to cause reasonable fear of imminent serious bodily injury or death.</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Probable cause to believe a person 16 years or older within the previous 4 hours assaulted a family or household member and believes (1) felonious assault occurred, or (2) assault resulting in bodily injury occurred whether injury is visible or not, or (3) any physical action occurred which was intended to cause reasonable fear of imminent serious bodily injury or death.</td>
</tr>
</tbody>
</table>

**Coded Relationships**: (A) current/former spouse, (B) current/former cohabitant, (C) child in common, (D) Dating relationship, (E) related by marriage or blood

**Source**: U.S. Department of Justice
References


