Legal and ethical issues in the court mandated treatment of batterers .

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The relationship between therapist and client/patient is fiduciary. In its usual manifestation, the role of the therapist is well defined and involves helping and supporting the patient's efforts to make positive changes in his/her life, and acting in the client/patient's best interests. The introduction of legal proceedings into a therapeutic relationship can disrupt the therapeutic process and complicate the therapist's perceptions regarding the client's best interests. For example, Dubey (1974) notes: "…what may be in a person's best legal interests, i.e. maintenance of dramatic symptoms in order to present a sound case for disability or liability, may be directly contrary to his therapeutic interests, i.e. relinquishing of symptoms" (p.1093). One of the most potentially disruptive elements concerns the ability of the therapist to protect the privacy of material divulged in the context of the therapist client relationship. Confidentiality has been described as the "sine qua non of patient-oriented therapy" and further, that "it's [psychotherapy's] very existence depends on the protection of privileged communication" (Hollender, 1965 as cited in Dubey, 1974). Yet, despite its importance to the therapeutic process, it is often poorly protected and there is a substantial body of case law in which mental health professionals have been compelled to divulge information obtained under the expectation of privilege. In situations where the client is court mandated, breaches of confidentiality may be more than embarrassing or inconvenient, they may result in serious legal consequences such as revocation of parole, or probation, and land the client in jail. Dealing with court mandated clients is sufficiently rare that therapists may not receive much training regarding the legal and ethical issues encountered when working with this population. The enactment of domestic violence legislation in many states has led to a dramatic increase in the numbers of individuals court ordered to undergo some form of intervention. Court mandated therapy requires the therapist to balance the often competing interests of the batterer, and the legal system. Is the therapist an agent of the courts or an advocate for his/her client? This chapter examines the issues and choices a therapist must make, when engaging in court ordered treatment of batterers, and the

implications of those choices for both therapist and client.

Many states now have legislation in place which permits judges to mandate batterers into treatment or intervention programs. In some cases (e.g. Phoenix, AZ) the batterers treatment program is offered to domestic offenders as a diversionary program. Batterers are assigned a future court date, by which they must have completed a batterers treatment program or face prosecution for their offense. In other jurisdictions (e.g. Massachusetts), the treatment mandate is specified as a term of probation, following either a plea or a guilty verdict. From a legal perspective, these alternatives have very different attributes and consequences which do not concern us here. In either case, however, mandated treatment presents complicated practical, ethical, and legal considerations for the treater. Most states which allow for court ordering of batterer treatment also have standards in place, or are in the process of developing standards, for the certification of programs. These standards, which vary from state to state, may specify program length and/or content, format (e.g. group vs. individual, gender specific vs. couples), minimum credentials or training for treaters and/or program sponsoring organizations, reporting requirements (e.g. to the victim, probation department, or courts), and the circumstances under which confidentiality is limited. For a complete discussion of batterer treatment standards see the special issue of the Journal of Aggression, Maltreatment, & Trauma (In Press).

Despite wide use of the term "batterers' treatment" as a generic description of the endeavor, there is substantial support for the idea that this is not treatment in the psychotherapeutic sense of the word, but rather an intervention, and, in fact, many states (e.g. Massachusetts) have adopted the term "batterer intervention" to describe the treatment option available to the courts. In part, this stems from a concern that partner abuse be viewed, not as a psychological problem, but as a criminal behavior. A second function is to remove batterers' treatment from the realm of mental health professionals, where ethical considerations regarding confidentiality could conflict with the reporting requirements of many state standards. Next is the concern that classifying partner aggression as a psychological problem would permit attorneys to make diminished capacity defenses and allow batterers to divert some responsibility for their behavior to their "mental problems". Finally, the orientation of many well known programs (e.g. Emerge) emphasizes protection of the victim by monitoring the behavior of batterers, a function that would be seen as antithetical to the development of a therapeutic alliance. For purposes of clarity and convenience, the terms treatment and intervention will be used interchangeably in this

chapter. In those instances where a distinction between the two is being made, the exception to this usage will be clear from the text.

The term "batterer's treatment" is of little heuristic value given the broad range of interventions it subsumes. Programs vary in length, orientation, content/curriculum, format, leadership, and philosophy. Some more closely resemble educational driving programs for DUI offenders while others are indistinguishable from psychotherapy groups. The credentials required for group leadership are also disparate. Many states (e.g. Massachusetts) fail to specify any minimum professional credential, instead requiring a minimum period of training (which may be as brief as one day) from a recognized program (e.g. Duluth or Emerge). Some, but not all, jurisdictions prohibit ex-batterers from serving as treaters. The legal and ethical considerations discussed in this chapter pertain primarily to individuals in the mental health professions who are engaged in batterers' treatment with court mandated participants. Even among the various counseling professions, ethical obligations vary, thus social workers observe an ethical code different from that of psychologists or psychiatrists.

Court mandated batterer treatment is a relatively new enterprise, with most of the legislation permitting such mandates having been enacted only within the last decade. As a result, there is relatively little case law evolved specifically from cases in this field. This chapter will synthesize existing case law relevant to court mandated batterer treatment, case law addressing more general court ordered treatment, interpretations of the various codes of ethics governing the mental health professions, and the opinions of experts responding to queries regarding hypothetical circumstances. It will be written for mental health professionals, not lawyers, so we will make few assumptions regarding the legal knowledge of the intended readership.

Statutory Law, Case Law, and State Regulations

In the spirit of oversimplification, we begin with the term "case law". Many people are surprised to learn that much of what we term "the law" is not written as clear and specific rules for people to follow. Clearly defined rules, such as those governing speeding, are known as statutes, and the totality of these are collectively referred to as "statutory law". Statutory rape, for example, is a violation of a very specific written rule prohibiting a legally defined adult from having sexual intercourse with a legally defined child. Testimonial privilege [which allows a

patient to refuse allow testimony in court regarding their psychotherapy], in those states that have it, is also statutory. Another manner in which courts determine whether a wrong has been done is through the use of case law. Case law, according to Black's Law Dictionary (1990), is "The aggregate of reported cases as forming a body of jurisprudence, or the law of a particular subject as evidenced or formed by the adjudged cases, in distinction to statutes and other sources of law." More simply stated, case law is based on determinations made by courts related to a particular subject area. Although states generally refer to their own case law, federal case law and case law from other states can be used by a court in making a determination about a specific topic. Case law is often used to help shape state regulations and standards of practice. Much of the law regarding the behavior and liabilities of mental health professionals is drawn from case law. The irony of case law, of course, is that a person becomes liable, or grounds for a finding of malpractice are determined, after the fact. Consequently, even the most well meaning, ethically aware therapist can run into legal trouble. It also means that until specific cases are actually brought, all one can do is speculate about how to deal with situations such as the ones that are the subject of this chapter.

Although states often refer to case law determinations from other states as a basis for rendering decisions, one state court is not mandated or even obliged to rule in the same manner as a court in other state, even though the issue at hand may be very similar or the same. An interesting example of this is a review of the case law that followed the landmark case of *Tarasoff v. Regents of the Unversity of Califonia.*

In July of 1969, Prosenjit Poddar, a graduate student at the University of California, attended therapy at the Student Health Center of this university. During a session, he informed his therapist, Dr. Lawrence Moore that he intended to kill an unnamed young woman with whom he was infatuated. The psychologist alerted the campus police and his supervisor to this threat. The campus police found Poddar and after convincing the police that he was not dangerous, was released from their custody. Two months later, Mr. Poddar stabbed Tatiana Tarasoff to death. Ms. Tarasoff's family then sued Dr. Moore and the State of California for malpractice, asserting that there were actions that Dr. Moore could have taken that would have prevented the victims death. In 1974, after determining that because Dr. Moore had a special relationship with Poddar, the Supreme Court of California determined that the psychologist was negligent in his duty by his failing to inform Ms. Tarasoff of the danger she was in. In rendering its decision, the court

established case law that imposed upon psycholgists in California the duty to warn third parties of serious threats made against them. Upon appeal, in what is commonly referred to as *Tarasoff II*, the court expanded that duty of psychologists in California from duty to warn to duty to protect. As Douglas and Webster (1999, p.6) note, "Tarasoff entrenched in case law the idea that mental health workers ought to have the capacity to isolate and act on information that may have a bearing on future violent conduct."

Although Tarasoff set the stage for courts in other states to impose upon clinicians a duty to protect third parties, case law in other states have supported, expanded upon, and, in some cases, rejected the duty established by *Tarasoff*. Since *Tarasoff*, there have been a series of legal determinations in California and other states that have attempted to define what type of duty clinician's owe to society in regards to protecting third parties. In *Jablonski v. United States* (1983), a California case post-dating *Tarasoff*, the court determined negligence when the victim was identified only as a person who was close to the perpetrator of the violent act. In *Peck v. Counseling Services of Addison County* (1985) this duty was expanded to the protection of a third party's property. A more concerning ruling occurred in 1980. The finding in *Lipari v. Sears, Roebuck & Company* (1980) extended the duty of mental health professions to protect society at large (i.e., no specific individual had been threatened). It should also be noted that some state courts have rejected the duty of clinicians to protect third parties (e.g., *Boyton v. Burglass*, 1991).

The variability in these findings illustrates how courts in different states differ with regards how they define the responsibilities of clinicians to protect society. In spite of these various post-*Tarasoff* court decisions, Anfang and Appelbaum (1996) note that, although there are some exceptions, "courts have found a duty to protect only clearly foreseeable victims and clearly forseeable violent threats" (p. 70). Because of the inter-state variability, clinicians must be aware of the relevant case law in the states in which they practice.

As described above, case law can be used as a foundation in the establishment of state regulations that are germain to mental health professionals. As a result of *Tarasoff*, even states that did not have state specific case law, adopted state regulations identifying these duties in anticipation of such cases,. In many cases, the language of these state regulations is very specific and clearly defined. Clinicians who practice in states that have certification standards for batterer treatment must be aware that there are instances when these standards deviate from the duties

that state regulations impose on mental health professionals (usually licensed mental health professionals). To illustrate this point, let us continue to use the issue of a clinician's duty to warn or protect a third party in Massachusetts (a state where *Tarasoff* responsibilities are established by statute not case law). The batterer intervention certification standards in Massachusetts state:

The program must evaluate the perpetrator's lethality, with a particular responsibility to warn victims and current partners deemed to be at high risk. The program must warn all victims and current partners that any violence could be lethal and that lethality or continued violence is impossible to accurately predict. The program must inform the Chief Probation Officer in Charge and the referring court in writing and document all attempts to warn victims and current partners.

By reading this section of the certifcation standards, it could be presumed that clinicians in Massachusetts only have a duty to warn a third party if that person is identified to be "at high risk" of being harmed. This assumption would be inaccurate. Psychologists in Massachusetts have a very clearly defined (via Massachusetts General Laws, c. 123, s. 36B) duty to protect a third party of "a clear and present danger" of injury. This statute also articulates the precautions that a clinician should use to migitate the likelihood that the third party would be injured. These precautions include contacting the victim, notifying the police (not the probation department) of the threat, arranging for voluntary or involuntary hospitalization, or all of the above. A psychologist who responds to a threat of injury to a third party in the manner outlined in the certification standards could be accused of failing to fulfill the statutory requirements. Although they may have warned the intended victim and notified probation, for example, they did not directly contact the police or seek involuntary hospitalization of the batterer. It is important for those who work with court ordered offenders to be aware of the inconsistencies that may exist between certification standards, state regulations, and case law that pertain to the treatment of their clients.

Batterer Treatment, Identification Of Agency, and Confidentiality

Regardless of the nature of the intervention, the batterer is often a reluctant participant

and may not view the treatment as being in his best interests. Accordingly, he may view the treater not as an advocate, but as an arm of the legal, or judicial, system, and therefore be reluctant to disclose personal information that might be relevant to his treatment, for fear that such information might be used against him. This concern might or might not be founded. The batterer's liability stems from several sources. First, many programs regularly exchange information with the courts/probation departments. Adams (1994) noted that "generally, state standards of batterer treatment require that programs...inform courts about repeat acts of violence, alcohol or drug abuse, attendance, and overall progress" (p.9). Such programs share the batterer's view that the program is indeed an arm of the law and as Adams (1994) points out "batterer treatment programs are able to more closely monitor the perpetrator's abusive behavior than the probation officer alone" (p.5). The batterer may rightfully believe that disclosing angry feelings, alcohol use, or aggressive behavior might cause his probation to be revoked and lead to imprisonment. It should also be noted here that state standards which require that programs inform the courts about repeat acts of violence, alcohol or drug abuse, attendance, and overall progress may be asking mental health professionals to violate confidentiality for reasons other than those specified in either their Tarasoff duties or their ethical code.

A second reason for the batterer's suspicions derives from uncertainty regarding the requirements for treatment completion. He may fear that his probation will be extended and his termination from the program delayed if he discloses any negative feelings or behaviors. Such concerns may prevent the batterer from engaging in the therapeutic process and may diminish any potential gains from program participation to those that would be obtained by incarceration (i.e., completing sentence with no hold from probation).

The therapeutic process requires an alliance between the treater and the patient and the belief by the patient that the has his best interests at heart. It is for these reasons that confidentiality is the cornerstone of the psychotherapeutic relationship, and that information acquired in a therapist-client relationship is legally protected as privileged communication. In *Jaffee v. Redmond* (116 S.Ct. 123, 1996), a case that established a patient's right to prevent a therapist from disclosing clinical information regarding the client, the Supreme Court noted:

Effective psychotherapy…depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult

psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For these reasons, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.

In rendering its decision in *Jaffee v. Redmond*, the court was asked to rule on a case where there was a clearly defined client-therapist relationship. Although clinician-client confidentiality is, in many states provided by statute and has been repeatedly endorsed by case law across states, the interface between the judicial system and the therapist which is created when therapy is court mandated presents challenges as to when and and how information is shared with others. This problem emerges when programs who treat batterers define the client of their services as individuals, or institution, other than the batterer himself.

Perhaps the largest philosophical difference between programs that work with domestically violent men is the identification of "agency." Agency, according to Gutheil and Appelbaum (2000), refers to how a clinician (or organization) defines who is the client of their services. Programs that work with domestically aggressive men often differ in whom they define as the "clients" of their services. Some programs view the court as their "client" and report all information discussed in treatment/intervention sessions to probation or other officials of the court. The identification of the court as the client of these programs' services appears to be a logical one, given that the court is the impetus for treatment and the completion of treatment a term of probation. Many programs, especially those self-identified as pro-feminist tend to view themselves as extentions of the court.

In contrast, other programs identify the batterer as the client of the program. This should not be taken to imply that victim safety is less important to these programs than others; rather, it identifies the batterer and his aggressive behaviors as the focus of therapeutic intervention. Whereas programs which identify the court as the client of their services tend to employ a social control framework as the focus of their intervention, programs that operate with the batterer being identified as the client of their services focus on providing internal change as catalyst for the cessation of violent behavior. The "batterer as client" model assumes a more traditional treatment approach, including concerns about how sharing information with outside parties impacts the batterer's ability to truthfully share information in treatment. Clinicians who treat batterers from this more traditional framework have greater concerns about how information is disseminated to the court than those programs who identify the court as the client of their

services.

Most programs that work with batterers, however, have, either explictly or implicitly, what Appelbaum and Gutheil (1991) describe as "split agency." Split agency refers to having more than one identified person or party as clients. In the treatment of batterers, split agency could mean that a program has some allegiance to the court, victim, and/or the batterer. According to Appelbaum and Gutheil, "Split agency is not necessarily a problem; ethically, however, candor is required to delineate the nature of the agency before material is explored in any situation where agency is not limited only to the patient" (1991, p.21). In other words, prior to entering any type of intervention or treatment, the individual working with the batterer must inform him of how the information that is discussed in treatment sessions will be used and who will have access to the information.

Anytime information in a therapeutic relationship is disclosed to outside parties, particularly if it is released to more that one party, issues of confidentiality and privilege can arise. Putting aside the argument that the batterer may rightfully believe that disclosing angry feelings, alcohol use, or aggressive behavior might cause his probation to be revoked and lead to imprisonment and that such a belief may impair his ability to openly participate in treatment, is it illegal or even unethical for psychologists to unilaterally share such information with the courts and victims? Are they at any increased risk of litigation from this practice? The answer to these questions is: not necessarily.

For psychologists or other licensed professionals who, either by ethical standards, case law, or state statute, have confidentiality and privilege requirements, the clarification of agency is of particular importance. However, before we can address why the establishment of agency is so important to these professionals, it might be helpful to define these terms and provide a historical basis for why the priniciples are so important.

Confidentiality "refers to the right of an individual not to have communications that were imparted in confidence revealed to third parties" (Appelbaum & Gutheil, 1991, p. 4). Privilege, or "testimonial privilege" as it is often referred to, applies only in legal contexts. It is the right of an individual, under certain circumstances, to prevent another person from providing testimony during a legal proceeding about that person based on information that was provided in confidence (Appelbaum & Gutheil, 1991). According to Beck (1990), 49 states have "laws stating that information about patients is privileged (p.6)," although the language of these laws

and to whom they apply varies from state to state. It is notworthy, however, that in Federal courts, where Federal Rules of Evidence apply, there is no explicit right to clinician-patient privilege. Instead, the court has "the power to create privilege on a case-by-case basis" (Appelbaum & Gutheil, 1991).

The concept of confidentiality has evolved over the past 30 years as legal scholars have interpreted the the U.S. Constitution to imply a "right to privacy." Although the word "privacy" is never actually used in the Constitution, "the Supreme Court has reasoned that the term 'liberty' in the Fourteenth Amendment implies certain privacy rights" (Behnke & Hillard, 1998, p. 26). In addition to these legal reasons, psychologists, as we have already discussed have been trained to believe that it is necessary for effective treatment that communications between therapist and clients be private and confidential. Although the research on this topic is equivocal (Appelbaum, 1985), it is presumed that without such protection clients will not honestly share their real thoughts and problems in treatment. In doing so, clients would be compromising the therapists ability to assist them in making the types of changes that they wish to have occur. Considered to be so central to the therapeutic relationship, the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992) have established guidelines related to ethical conduct related to preserving confidentiality in the therapeutic relationship.

It should be noted that psychologists, and other licensed professionals, depending on case law or state statutes, can undergo disciplinary action by a sanctioning agency (i.e., the American Psychological/Psychiatric Association or National Association of Social Workers) and/or be sued in civil court over a breach of confidentialy. However, it is not uncommon for state statutes defining who has confidentiality requirements to have no specific provisions for those individuals who provide batterers interventions or treatment. Massachusetts General Law (M.G.L. c. 233, s.20), for instance, explicitly identifies a number of counseling disciplines, including domestic violence victim's counselors, as professionals having confidentiality requirements, but makes no similar provisions for the professionals who treat male batterers. Although some individuals who provide batterer treatment or intervention in Massachusetts may have licensure that mandate confidentiality and privilege via state regulations, others may have no provision under state law or regulations allowing confidentiality.

For those professionals who have confidentiality requirements, the promise of confidentiality is not an absolute principle. In fact, there have always been exceptions to

confidentiality, mandated by either by state law or regulations. Although states vary with regards to the circumstances under which confidentiality can be breached, clinicians can usually "break" confidentiality for several reasons. These include: mandated reporting of instances of child and elder abuse and the threat of injury towards others or the client himself or herself. Because of these noteworthy exceptions to confidentiality, APA ethics (American Psychologiocal Association, 1992), the "aspirational" Specialty Guidelines for Forensic Psychologists (Committee on Ethical Guidelines for Forensic Psychologists, 1991), and state regulations in many juridictions require licensed clinicians at the onset of the professional relationship to inform their clients of the circumstances under which they will provide information to others. This warning is usually labeled as the Limits of Confidentiality (see for example, Massachusetts General Laws, c. 117, s. 129A; APA Ethical Guidelines, 1992).

Depending on the treatment program's identification of agency, there may be other information that clinicians should impart to batterers upon entering a program. For example, if a batterer's intervention program identifies itself as an agent of the court, it is important for that program to inform the batterer what information will be provided to the court or other parties at the onset of the intervention or treatment relationship. The clearer the program is in identifying agency, the clearer it will be when informing the batterer about who will receive information related to his or her intervention/treatment and the reasons for this disclosure. Licensed professionals (or at least the ones indentified by state regulations) could be sanctioned, lose their licenses, and/or be sued, if they reveal information to outside parties without the permission of the batterer. As Behnke and Hillard (1999) assert, "The four words you never want a client to begin a sentence with are: 'You didn't tell me…'" (p.32).

Certification standards in most states also require contact with the victim of the abuse and/or current partner of the batterer. It is no less important that these individuals be notified about how the information they share with the treater will be used. If the program openly reports all information to probation, the victim should be informed of this. It is important to keep in mind that the victim has no obligation to speak with any clinician, and may have legitimate reasons for not doing so. If a victim chooses to share information, she should be advised prior to her revealing the information to whom the content of her statement will go. By failing to inform her of who will receive the information, the clinician may be placing her at greater risk of injury. For instance, should the victim report that the batterer has remained aggressive to the treater

thinking that the information would be used for treatment purposes only and then finds out that her husband has been rearrested for violating probation, she may be angry that her information has been used in this way, incur his wrath or retaliation for "ratting him out", suffer a loss of income as he is unable to continue earning income, or suffer some other consequence of having an incarcerated partner.

Cooperation between the various agencies involved in domestic abuse cases is viewed as an important strength by many batterers treatment programs. VAWnet recently published a review of standards for batterer intervention programs (VAWnet, 1997) and noted that "a coordinated community response in ending domestic violence is stated as being necessary in 97% of the standards…" (p.4). Sixty-one percent of the standards require that new incidences of violence need to be reported to the authorities. One of the more extreme examples of this practice is the Emerge program which provides the courts with weekly attendance reports, periodic progress reports, and immediate notice of any status change (Emerge, 1998). What, if any, are the limits to cooperation between the treatment program and other agencies? On several occasions our program has been contacted by a probation officer informing us that an arrest warrant had been issued for one of our group members (court mandated) and requesting that we notify probation if he attended group so that he could be arrested. Does the therapist have any obligation (legal or ethical) to comply with such a request? In these cases, we have taken the position that we would inform the batterer that a warrant had been issued and advise him to turn himself in to the police or probation, but we would not notify either the police or probation department of his arrival at group. In each of the cases, the batterer failed to attend group once the arrest warrant had been issued, effectively extricting us from this dilemma.

Situations like one above arise when there is a confusion of agency by a third party. It is, therefore, important to clarify not only the type of information that will be shared with these parties, but the program's view of its relationship with the third party (i.e., the court). Although some programs who view their role as being an extension of the court may have indeed contacted the court of the batterer's whereabouts, other programs, such as the UMass program, do not feel compelled to respond to this demand. Although it is impossible to foresee every possible boundary problem with agency, open discussion with the other agency or court about what the program will and will not do should be discussed as the issues arise. By doing so, the treating program and the other parties will have a clearer understanding of the boundaries that may exist

between them, which then can be articulated to the batterer.

Although not generally discussed in the context of batterer treatment, the doctrine of informed consent nevertheless still applies for many clinicians. The Ethical Principles of Psychologists and Code of Conduct (APA, 1992, s. 4.03) recommend that "Psychologists obtain appropriate informed consent to therapy or related procedures, using language that is reasonable understandable to participtants." But how is this issue directly relevant to the treatment of a batterer? In order to understand the neccessity for providing and receiving informed consent for treatment, it will be necessary to review how the doctrine of informed consent was established.

Simply stated, the "doctrine of "violenti non fit iniuria--no harm is done to one who consents—is the legal maxim that underlies the informed consent doctrine" (Ogloff, 1999, p.409). One of the first court cases to address the issue of informed consent was heard by the Kansas Supreme Court. Although the case was concerned with a physician who was accused of failing to inform a patient of the risks of radiation treatment for cancer, *Natanson v Kline* (1960), and later *Canterbury v. Spence* (1972), established the parameters about what information should be provided to individuals who are about to engage in any form of treatment. According to Grisso and Appelbaum (1998), "Patients must be told about the nature and purpose of the proposed treatment or procedure, it's potential benefits and risks, and the alternative approaches available, along with their benefits and risks" (p.7).

To determine whether the requirements of informed consent have been met, there should be an assessment of the three elements that underscore the basic principals of this advisory Melton et. al. (1997, p.346) wrote: "Determining whether informed consent is valid requires consideration of…disclosure, competency, and voluntariness." But what do these elements actually mean and how do they related to the treatment of batterers? The first element, disclosure, refers to whether a clinician has provided adequate information about the type of treatment the batterer would receive (including benefits and potential risks) that would allow him or her to make a reasonable decision about attending treatment. The content of the information that must be provided to meet this requirementvaries from state to state but is typically conceptualized either as "whether a reasonable clinician would disclose particular information under the same circumstances" (Melton et. al, 1997, p.346) or, as Grisso and Appelbaum (1998) note, that in patient-oriented disclosures, clinicians "must disclose the information that a reasonable patient would find material to a decision about the proposed treatment" (p.8). Some

states use the "reasonible clinician rule" while others use the "reasonible patient rule". Although there may not be consensus about what type of information should be shared at the onset of batterers treatment, information should be given that provide the batterer with enough information about the program to decide whether or not he wishes to participate in that program. Even though batterers are often court mandated into treatment and failure to attend treatment could result in a violation of probation and incarceration, theoretically they still have a choice regarding whether they attend treatment or not. An unemployed batterer, for example, after being informed of the fee structure for the program, may decide that he would rather go to jail and complete his sentence than participate in treatment. His logic for this decision may be that he will likely fall behind in his payments, be terminated from a program half-way through, and then be sent to jail, anyway.

This type of decision making leads us to a discussion of the other elements of informed consent, the concepts of voluntariness and competency. Simply because a client is informed of the risks and benefits of a form of treatment, there is no guarantee that they actually undertand or fully appreciate the information presented to them to the extent that they can make an informed decision. As with other types of competency evaluations (e.g., competency to stand trial), assessment of an individual's competency to consent to treatment is a functional assessment. That is, does the individual have enough intellectual or cognitive capacity to understand the type of treatment he or she is about to receive and the consequences, positive and negative, of participating in a particular type of treatment? Although it is true that in most court ordered situations assessment of whether a defendant is competent to make informed decisions about participation in a treatment or intervention program is not often an issue, there are times when a more formal assessment of this issue should be pursued. For example, it is conceivable that a cognitively limited individual could be ordered into treatment. If a cognitively limited batterer does not fully understand what is required of him to complete the program, he may become treatment non-compliant because he did not comprehend the "risks" of missing sessions or not talking in group (both behaviors that could result in termination from a certified program in Massachusetts).

The last important element to informed consent is that the client makes his decision to participate in treatment voluntarily, based on his understanding of the type of treatment he or she is about to receive, and that decision is not coerced. This issue of what consititues unacceptable

levels of coercion is an interesting one. When a batterer enters treatment because his wife threatens to divorce him or have him arrested the next time he is abusive, is the batterer being coerced into treatment? When the court orders a batterer into treatment or intervention program as a term of his probation and informs him that if he fails to attend the program he will go to jail, does this level of coercion invalidate a batterers consent for treatment?

In response to the first question, Grisso and Appelbaum (1998) suggest that these types of threats would not invalidate the batterer's consent because "family members and others in patient's lives are entitled to make demands on them as conditions for continuing their relationships…clinicians need not refrain from initiating treatment because a patient has consented out of concern for the reaction for the loved one." (p.6). In regards to the second question, when a defendant is found guilty or accepts a plea bargain to a domestic assault, he will likely be asked if he is willing to attend a treatment program as an alternative to going to jail. More often than not, the batterer under these circumstances will agree, often upon the advice of his attorney, to attend court mandated treatment and accept the plea bargain. In doing so, he is making an informed choice to participate in the program and has thus "voluntarily" agreed to enter treatment.

Although courts have the power to mandate treatment as a condition of a plea bargain or probation either by state or federal regulations (see: 18 USCS s. 3551, 2000), this does not imply that the court can automatically have access to his or her treatment records without the probationer's permission. Even when therapy is court ordered, the patient retains the privilege and consent must be obtained, in most cases. The qualifying phrase "in most cases" was used because it is always possible for a court to subpoena a record without the patient's consent and while the therapist can ask that the confidence be protected, it is ultimately up to the courts to decide whether the privilege will be respected. If the the court orders the release of information, the therapist is obligated to comply with the court's request or risk the possibility of legal sanctions being imposed upon him or her.

This point is usually moot, however, since most courts/probation departments will compel a probationer to sign a release under threat of imprisonment and therefore, a signed release will almost always be in place prior to the start of treatment. If not, it will be soon after the therapist informs the court/probation officer that such a release is required before information can be divulged. What, then, should be a therapist's policy regarding a coerced release?

Providing that the therapist is not the one doing the coercing, the circumstances under which the release was signed does not, apparently, concern us. Individuals are always making decisions based on their appraisal of consequences and contingencies. The probationer has the choice of not signing the release, even if that might mean going to jail, just as he has the choice of going to jail in preference to participating in a diversionary program.

Many programs require the batterer to sign a release for probation or victim contacts as a pre-condition of treatment. Referring to the Duluth Model, Pence and Paymar (1993) state that "participants refusing to sign the release are not allowed to participate [in the program] and are referred back to the courts" (p.24). It is also possible for a batterer to give consent for release of certain information (e.g. his attendance at the program) while protecting other information (e.g. his progress or lack thereof). Again, there are both legal and therapeutic considerations. Batterers may be compelled to sign releases either by the courts or in order to be admitted into a program which the courts have required, and therapists may be able to accept such releases as valid, however, these limits around confidentiality may affect the batterers willingness to disclose information that might be important to therapeutic progress.

Other Ethical And Legal Dilemma's Associated With The Treatment Of Batterer's

The interface between spousal abuse and child abuse poses additional ethical dilemmas. In many states, it is considered abuse/neglect if the child witnesses interparental aggression. It is not necessary for the child to be otherwise abused. Thus, the treater has an obligation to make a report to the child protective services agency if he/she is aware of interspousal aggression. Using this interpretation, batterer's intervention programs would be obligated to file against all participants who had children living in the house. Several questions stem from this issue. First, if the batterer is no longer living in the house and/or is under a restraining order, would the obligation to file still be in force? Certainly, these measures might reduce the liklihood of further instances of this form of abuse/neglect. It might not, however, diminish any negative consequences for the child of having witnessed the abuse. Whether or not this should be a consideration would turn on whether the objective of child protective services is to prevent future exposure, or to remedy the consequences of past events. In many cases, the involvement of child protective services is the impetus for the restraining order and absent agency influence, the probability of the household reconstituting might be increased.

Police and/or court involvement raises a second issue. Since the police and the courts are mandated reporters (of child abuse/neglect), is it reasonable for the treater to assume that if a report to child protective services was indicated, that the police and/or the courts would have made the report. Further, if this is a reasonable assumption, does it eliminate the obligation of the treater to make the report? Looked at another way, does the fact that the police and courts have not made a report to child protective services indicate that such a report is not warranted? In our opinion, neither of these asumptions is acceptable. Whether or not another treater (or mandated reporter) has complied with their legal and ethical obligation does not necessarily alter the obligation of other mandated reporters. The failure of the court or the police to make a report does not excuse other mandated reporters from making a report. Similarly, the assumption that someone else has already filed a report does not necessarily relieve a mandated reporter of responsibility to report. If the therapist has a reasonible basis for believing that a report has been made (e.g., the information comes from a reliable reporter, such as another therpist, school official, the court), it may not be necessary to file a report. On the other hand, if a parent reports abuse to a therapist but states that a report has already been filed (say by a teacher or physician), the therapist might want to confirm this with child protective services. Unfortunately, the statutes are ambiguous regarding the obligations of multiple reporters. Some agencies designate a reporter who files on behalf of the agency thus avoiding duplication by different treaters within the same organization.

It is important for therapists to remember that court ordered batterers are almost always on probation and face the possibility of incarceration for any violation of the terms of probation. Programs which routinely violate confidentiality for even the suspicion that the batterer might become aggressive should be aware that they are taking actions which could substantially impact the life of the batterer and his family. Reports to child protective services fall into this category. While reported physical abuse or neglect of the child must be reported under state law, exposure to aggression between parents that has occurred in the past is less definite, and may allow for greater discretion by the therapist. Therapists should be aware of the consequences of reporting, not only for the batterer but also for the female partner. The report could be viewed by the courts and probation as a subsequent offense and compromise his probationary status. Even if it does not, it could be taken as additional evidence of his aggressiveness and influence future court involvements (e.g. custody or visitation decisions). Child protective agencies often require the

mother to obtain a vacate or restraining order against the batterer as part of the service plan, forcing the batterer out of the house which could have negative consequences for her (financially, and safety wise) and further disrupt family functioning (Emerge, 1998).

A related problem concerns how to handle reports by the batterer that the mother is abusing the children. As a mandated reporter, the therapist would ordinarily be obligated to file a report with child protective services. However, batterers in treatment would be aware of this, having been warned of the exceptions to confidentiality at the initiation of treatment, and could intentionally try to cause trouble for their partners by fabricating stories of abuse by the mother. The therapist would thus be colluding with the batterer to harrass his victim. Even more concerning would be the fact that a report by a mental health professional might add weight to the report, increasing the possibility of some action by child protective services. On the other hand, victims of abuse may be more likely to abuse or neglect their children and the possibility that the batterer's report is accurate cannot be discounted. Straus (1990) reported that "the more violent husbands are toward their wife, the more violent the wife is to her children" and that even battered women who had been subjected to minor violence (i.e. pushes and slaps) "had more than double the rate of frequent severe assaults on their children than did wives whose husband's did not hit them" (p. 421). Protection of the children would dictate that a report to child protective services would have to be made.

To the lay person, any bad outcome may be viewed as malpractice. If a patient hurts someone else or themselves, the therapist should have predicted and prevented it. In this regard, therapists have been held to an almost impossible standard. Legally, the term "standard of care" is used to ascertain liability. Standard of care refers to the accepted practice with respect to a specific problem. Thus the judgment is not based on outcome but rather on whether the therapist provided standard, or sub-standard, treatment. This acknowledges that a therapist could do all the right things but the patient could still have a bad outcome, and that under such circumstances, the therapist would not be held liable. Written standards may be developed by professional organizations, or within agencies (e.g. by a hospital, practice, or clinic), however, they are rarely considered definitive. In many cases, there are no written standards, and in any given case, standard of care is determined by which side produces the most convincing experts. In the area of batterer treatment, the question arises as to whether state standards (if they exist) define the standard of care and whether failure to comply with those standards creates liability for the

therapist. Batterer treatment standards typically have been developed by committees which include battered women, representatives of law enforcement, and/or the judicial system, victim advocates, representatives from batterer intervention programs, and in some cases, researchers or other experts. Representatives from specific mental health disciplines are not necessarily excluded and may be included because they satisfy one of the other criteria (e.g. a psychologist who operates a batterer treatment program). In any case, the ethical requirements of any particular mental health discipline will probably not guide the development of the standards, and therefore, state standards should not define the standard of care for the provision of batterer intervention by the various mental health professionals. In general, standard of care is discipline specific, thus psychologists may be held to a different standard of care than social workers or psychiatrists. In our opinion, then, a psychologist who does not comply with certification standards because they are inconsistent with the ethical practice of psychologists, would be held to the standard of care paracticed by other psychologists and not those defined by state standards. An exception might be in states (e.g. Utah) where all providers of batterer treatment are required to comply with the certifications standards.

In summary, batterers treatment subsumes a diverse set of interventions, administered by practitioners representing a variety of disciplines, and philosophical orientations. Programs vary with respect to whether they view their roles as management and control of batterers or psychotherapeutic treatment of batterers; whether they view the batterer, the courts, or the victim, as their client; whether they view themselves as an agent of the legal system or as supportive change agent for the batterer. Where a treater stands on these various dimensions will influence important therapeutic constructs such as the confidentiality of information provided by the batterer, which may, in turn, influence the nature of the information provided by the batterer, and the degree to which he is able to engage in, and benefit from, the intervention. Although there is a dearth of case law specific to batterer treatment, relevant case law bearing on psychotherapy, in general, suggests some guidelines:

1. Batterer treatment programs should be clear about their views regarding agency and communicate this to the batterer at the start of treatment.
2. Full disclosure of the nature and limits of confidentiality should be explained at the initiation of the contact between the batterer and the program. The types of

information that will be disclosed and the parties to whom it will be disclosed should be specified.

3. Treaters opting to disclose information for reasons other than those delineated in the ethical guidelines of their professions should obtain a signed release from the batterer.
4. It is reasonable for programs to refuse to treat batterers who refuse to sign releases allowing exchange of information with the courts, victims, or probation officers. A release obtained, even under the circumstance where treatment is contingent upon signing the release, is valid and is not considered to be coerced.
5. Participation is considered to be voluntary, even if the batterer agrees to attend in order to avoid incarceration.
6. Standard of care is defined within each of the disciplines and is not determined by batterer treatment standards, which may be influenced more by political objectives than by therapeutic concerns.
7. Programmatic decisions regarding agency and limiting confidentiality may impact on the willingness of batterers to engage in (as opposed to attending) treatment as well as on the effectiveness of the intervention.
8. Victim contacts, however well intentioned, may place the victim in jeopardy and must be carefully reasoned and implemented. Victims should be informed regarding the intended use of the information they provide.

A number of other important considerations were discussed, especially those regarding mandated reporting of child maltreatment.. Although providers are bound by these regulations, concerns were raised regarding reporting the witnessing of aggression by children and the possibility that the batterer could use the treater to harrass his partner by falsely representing her behavior and precipitating a report to the authorities.

We are unaware of any research comparing treatment outcomes between programs which protect confidentiality to the extent dictated by the professional ethics of the various mental health disciplines and those which more readily make reports to victims, probation, and the courts. Without empirical tests, we can only speculate that protection of confidentiality would

facilitate participation in treatment and improve outcomes. The answers to many of the questions raised in this chapter await both future research and future lawsuits.

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