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Battering and Couples Therapy: Universal Screening and Selection of Treatment Modality.

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As family therapists begin to experiment with couples treatment models for batterers and their partners, a basic question is: Which couples can be safely treated with conjoint therapy? Following a definition of battering and a review of rationales for considering couples therapy in cases of domestic violence, a framework for assessment of domestic violence is outlined, including sample questions, criteria for excluding couples from conjoint therapy, how to conduct a lethality assessment, and how to conceptualize post assessment treatment recommendations. This article also introduces family and couples therapists to domestic violence literature that is often not well integrated in family therapy theory and practice.

There is little consensus among marriage and family therapists about how to conceptualize and treat domestic violence cases, as demonstrated by the polarized controversy about whether couples or conjoint therapy for battered women and their partners is or is not dangerous, unethical, or ineffective (see, e.g., Avis, 1992; Bograd, 1992; Erikson, 1992; Kaufman, 1992; Meth, 1992). Recently, family therapists whose work is characterized by sensitivity to issues of abuse, gender inequity, trauma, and analyses of power have experimented using couples treatment with domestic violence cases (Brown & O'Leary, 1997; Goldner, 1992; Goldner, Penn, Sheinberg, & Walker, 1990; Jenkins, 1990; Jennings & Jennings, 1991; Lipchik & Kubicki, 1996; Lipchik, Sirles, & Kubicki, 1997; Shamai, 1996; Vivian & Heyman, 1996; White, 1989). Their example has encouraged many clinicians to apply this therapeutic modality with batterers and their partners. However, even advocates for couples' therapy warn that this modality is inappropriate and dangerous in some cases or populations. But exclusionary criteria for this modality are often implicit, vague, or too general. Thus, a basic question remains: How can therapists identify cases where domestic violence is present and make decisions about the appropriateness of couples' therapy in a way that minimizes risk for all participants?

The clinical assessment of whether domestic violence exists requires specific skills and knowledge. With the exception of Aldarondo & Straus (1994), there are few easily accessible articles in the marriage and family therapy literature that concretely outline a

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comprehensive assessment of batterers and their partners (for valuable book chapters, see Campbell, 1995; Davies, Lyon, & Monti-Catania, 1998; Feldman & Ridley, 1995; Hamberger & Barnett, 199j Hansen & Goldenberg, 1993; Holtzworth-Munroe, Beatty, & Anglin, 1995; O'Leary & Murphy, 1992; Rosenbaum & Maiuro, 1990; Rosenbaum & O'Leary, 1986; Saunders, 1992). This article provides a beginning framework to help clinicians assess whether domestic violence is present and how to make decisions about whether couples work can be considered. Following a summary of rationales and cautions for employing couples work, battering will be defined. The universal screening protocol will be outlined, with a focus on the sequencing of meetings, the assessment of violence and lethality, evaluating the feasibility of couples work, and the clinical management of the disclosure of domestic violence.

Because of the low numbers of battered husbands (Geffner, 1997; Holtzworth-Munroe, Smutzler, & Bates, 1997; Saunders, 1988; Schwartz & DeKeseredy, 1993), the focus of this article is on male violence in heterosexual couples. The focus of this article on heterosexual couples is not meant to minimize the prevalence or importance of lesbian or gay battering. While many of the points made here may be helpful, the therapy of gay and lesbian batterers and their partners requires its own careful assessment that takes into account the oppressive and prejudicial social dimensions shaping gay and lesbian intimate life in our culture (Renzetti, 1997). Furthermore, race and class issues are not emphasized here (see Bograd, this issue). Culture and class sensitivities are essential features of clinical interviews from the first moment (Cervantes, 1993; Williams, 1998). For example, European Americans more often disclose domestic violence in clinical settings and engage in therapeutic discourses about domestic violence that revolve around establishing equality or leaving abusive relationships. These practices and basic values are not familiar in many other cultures (Carrillo & Tello, 1998; Mederos, in press; Williams, 1998). However, the initial domestic violence assessment described here focuses more on eliciting concrete behavioral descriptions of the nature, function, impact, and contexts of domestic violence, and less on meanings and norms that may be mediated by social location and whose importance is critical in subsequent treatment. The assessment protocol outlined here cannot simply be employed with all populations without extensive adaptation that is beyond the scope of this article. However, this preliminary effort can provide a guide to the development of more specific and culturally competent protocols.

RATIONALES FOR COUPLES THERAPY WITH DOMESTIC VIOLENCE

Various theorists and practitioners offer a range of rationales in favor of the viability of couples therapy in clinical situations involving domestic violence. These should be taken seriously, but with caution. Some acts of male aggression may have low impact on spouses (Ehrensaft & Vivian, 1996), suggesting that couples work may be safely employed in some cases without endangering the woman (Brown & O'Leary, 1997; Vivian & Heyman, 1996). Couples sessions quickly reveal the man's tactics of control and the function of his rage and domination in ways that are sometimes never seen in group or individual therapy (Rosenbaum & Maiuro, 1990). Couples therapy may impact

the relational factors associated with male violence (O'Leary & Murphy, 1992; Vivian & Heyman, 1996). The therapist can short-circuit the man's deployment of vulnerability to excuse his behavior in order to maximize the man's commitment to nonviolent relational responsibility (Jenkins, 1990). Interpersonal dynamics can be unpacked to strengthen the man's awareness of the internal states and behaviors that lead him to choose violence and to strengthen the woman's ability to protect herself, supporting the couple's adaptive strengths (Goldner et al., 1990; Jory, Anderson, & Greer,1997; Margo]in & Burman,1993). An interpersonal perspective may heighten each person's sense of personal responsibility. Couples therapy can clarify whether the marriage can be preserved without violence or facilitate separation with decreased likelihood of danger and further victimization, given that it is a time of increased risk for the woman (Johnston & Campbell, 1993). Clients, as customers, should have the opportunity to make informed choices about the kind of therapy they desire (Hansen & Goldenberg, 1993; Lipchik, 1991) and may be less ashamed to seek marital work rather than specialized treatment (Eisikovits & Edleson, 1989; Hansen & Goldenberg, 1993; Shamai, 1996).

It must be emphasized, however, that rationales in favor of couples treatment with marital violence may be premature. As Sprenkle cautions, "we do not know enough to make definitive recommendations about if, when, and under what circumstances couples treatment is advisable. Clinical research has almost nothing to tell us at this point" (1994, p. 600). In addition, a primary concern about the wisdom of couples therapy is the woman's safety. A man may escalate his violent behavior when interventions are made in a highly volatile, unpredictable environment (Balcom & Healey, 1990; Bograd, 1984; Pence & Paymar, 1993; Rosenbaum & Maiuro, 1990). Our agreement with these reservations is tempered by our awareness that an increasing number of marriage and family therapists are choosing couples therapy once domestic violence is identified. We believe this is based more on their familiarity with this modality than on the systematic assessment of how safe and effective couples therapy is in a given case. It is also likely that domestic violence is under-identified in cases (Harway & Hansen, 1993; Harway, Hansen, & Cervantes, 1997). Although it has been argued that couples therapy should never be employed once domestic violence is identified, such blanket statements may lead some therapists to simply dismiss concerns. Both positions contribute to the polarization in the field. Because domestic violence takes many different forms (e.g., Gondolf, 1988; Holtzworth-Munroe, Bates, Smutzler, & Sandin,1997), it is unlikely that a single treatment modality will be maximally effective (Lipchik, 1991; Lipchik et al., 1997; Shamai, 1996).

It is inarguable that, regardless of treatment modality, minimizing risk and optimizing safety are central. In many cases, the presence and impact of domestic violence are not visible. The man's violence may also create distortions in the internal experience of each person and within their relationship that militates against acknowledgement of his abuse for both partners and slants the couple's public discourse toward denial and minimization. When this happens, a system in which the starting point is the man's violence and coercive control may appear remarkably ordinary in an intake interview

and may be characterized by superficial affability and lack of conflict. In addition, a couple's presentation is shaped by when the last incident occurred and their response to it (Walker, 1994). Thus, it is necessary to utilize a structured and focused intake procedure that incorporates universal screening for domestic violence regardless of the presenting problem. Therapists should assume risk for domestic violence in all couples or families that present for therapy until it is ruled out. A universal screening procedure incorporates an initial couples interview followed by separate interviews of each partner, in an attempt to create a safer environment for disclosure. It also sets the stage for excluding many cases from couples work based on various factors (e.g., severe violence), including others under a very specific contract focusing on the cessation of the man's violence, and on optimizing the woman's safety, assessing the strengths and feasibility of a range of interventions, and making appropriate referrals for all family members.

DEFINITION OF BATTERING

The obvious goal of assessment is to determine whether psychological or physical aggression has occurred and whether it constitutes domestic violence or battering. Battering is a form of abuse that occurs between two adult intimate partners who may or may not be married or living together. Usually, a primary aggressor employs intentional violence that varies in type, frequency, and severity, ranging from pushing to marital rape to homicide. Psychological aggression or emotional abuse almost always precedes the onset of physical abuse. Physical aggression alone does not constitute battering unless it serves to enhance the man's control of his partner, leads the woman to modify her behavior or daily life, includes psychological abuse, and instills fear and intimidation (Ganley, 1989; Hamberger & Barnett, 1995). This definition relies on more than the simple severity of a given assault. Even moderate violence (pushing, shoving, or a slap) accompanied by psychological abuse and coercion should be considered battering. However, a single act of moderate violence that is not reinforced by psychologically abusive or coercive behavior does not constitute battering. Severe violence within battering relationships can include repeated or frequent moderate acts of violence (pushing, shoving, and slapping), frequent destruction of property, sexual coercion through threats of violence or rape, and any act of violence that causes injury, no matter how infrequent. The terms abuse, domestic violence, and battering will be used interchangeably. Reflecting predominant patterns of domestic violence, we will refer to the batterer as he or the husband and his partner as she or the wife, with the reminder that many couples are not married.

PRECONDITIONS OF ASSESSMENT

In order to conduct a domestic violence assessment possibly leading to couples therapy, three conditions must be satisfied: the man's participation is voluntary, special agreements about confidentiality must be established, and an optimal therapeutic stance must be achieved.

Voluntary versus Mandated Treatment

It is our belief that the possibility of couples therapy rests on the man's voluntary participation. Couples work is contraindicated in court-mandated cases because of the severity of violence that typically precedes court action and because the offender's treatment motivation is often questionable. Likewise, men who are physically abusive and who are requested to attend treatment by child protection agencies should be included in couples therapy only in exceptional circumstances. The risk of the batterer's manipulation of couples therapy and coercion of his pas (e.g., by threatening to provoke the removal of children by the child protection agency) must be ruled out

Issues of Confidentiality

One of the most complex issues in the assessment of domestic violence is the modification of rules of confidentiality and ideas about keeping secrets in couples therapy. In relationships where there is male violence, the woman's secrecy is not pathology or dysfunction in the usual sense but an essential self-protective measure to forestall retaliation or to give the appearance of compliance with arbitrary or unilaterally imposed rules. For the couples therapist, this poses many complicated issues surrounding how to obtain enough information so that the therapist has a relatively clear sense of the nature and extent of the man's violence without compromising the woman's safety. One way to do this is to explain to the woman that the material from the individual assessments will be kept private until the person chooses to share it within couples meetings. This, of course, challenges conventional family therapy ideas that a therapist's neutrality is compromised by secrets, which leads many therapists to state that anything shared in individual sessions must be able to be shared in couples meetings. Once domestic violence is identified, the therapist must not in any way pressure the female client to disclose information about her partner's abuse in couples meetings before she is willing, nor should the therapist share information provided by the victim without her permission. This assumes that there is no evidence that children are being harmed or neglected in ways that are reportable. In addition, whether or not the woman is willing to discuss the man's violent behavior in his presence is an important criteria of whether couples treatment is possible.

Therapist Stance

Careful self-monitoring is essential for the therapist. Domestic violence shapes the therapeutic relationship in complicated ways, especially concerning how a therapist balances trust in self-report with the awareness that self-report may not reflect reality. Battered women may not talk openly, may not feel safe discussing fear, or may downplay their level of risk. Batterers often appear charming or engaging. It is challenging to sort out truth from manipulation, unconscious denial from deliberate deception, or to reconcile one's experience of this man with what is learned about his private behavior. The battered woman's fear and rage may be contagious or off-putting. Careful assessment may not reveal domestic violence initially, and learning of its

presence or true extent later distresses many therapists and leaves them doubting their perceptions or competency. Even seasoned therapists report losing their clinical footing because of extreme countertransferential reactions such as fear, anger, disbelief, and minimization. These reactions often intensify when children are involved.

It is helpful to define these reactions as normal and natural responses to being part of a couple/therapist system, marked by listening to accounts of male violence, rage, fear, denial, and hurt, which may be intensified by the therapist's own personal history. In addition, therapists' reactions may have real foundations, since the therapist may become one of the targets of the man's verbal or physical assault. Therapists often find it helpful to meet couples in office spaces where others are present, to park their cars in lighted or public places, or to alert others to anxiety-provoking meetings. The therapist's sense of safety and his or her ability to create a context of self-protection is a necessary precondition of an optimal therapeutic stance.

The therapist must demonstrate a curious and persistent focus on details of painful or disturbing behavior, an ability to tolerate these details with compassion and without emotional reactivity, and a fair open stance. The therapist must be frank and clear about the allocation of responsibility and the inappropriateness of abusive behavior regardless of circumstances. The therapist can do this through a persistent focus on the male client's behaviors and their harmful effects and through presenting suggestions for safety strategically framed in his self-interest: "If you hurt someone, you drive them away and risk destroying the relationship." Or "You probably feel justified every time you do this. That's normal-that's the way it happens to everybody. That will not go away soon. But you have to be prepared for the next time you will feel the same way."

Clear limits must be caringly but directly presented to the perpetrator without dehumanizing the complexity of either spouse's experiences, disbelieving their often strong bond to each other, or shaming them. It is advisable to maintain an attitude of friendly and supportive skepticism that constantly questions the depth of the batterer's resolve and realism. Whenever he makes a commitment to a safety plan, it is appropriate to ask him whether the plan is realistic, to remind him that the trigger situation will occur again, and to ask him how he is most likely to sabotage his commitment. Does he agree too quickly to suggestions? Does he seem overly controlled? Whenever a new and intense topic is introduced, the therapist should inquire whether there is a risk of retaliation, what form that retaliation can take, and how he plans to avoid retaliating. Supportive skepticism also calls for scanning both clients' nonverbal language to see whether it contradicts their statements. If the man glowers or acts in an intimidating way with the therapist or his partner, the intentions and intimidating impact should be pointed out and limits set on such conduct. It should be clear that therapy can only occur in a climate free of fear and intimidation and of behaviors such as yelling or interrupting.

THE SEQUENCE OF THE ASSESSMENT

Research suggests that the majority of couples experiencing domestic violence do not disclose the man's abuse in early interviews. Two-thirds of couples presenting at an outpatient marital therapy clinic did not report domestic violence until specific clinical inquiry, due to embarrassment, fear, shame, social stigma, lying, minimization, or defining other marital issues as more pressing (Ehrensaft & Vivian, 1996). The following assessment protocol prescribes a sequence of meetings to optimize the identification of domestic violence while suggesting ways to regulate the disclosure of information to reduce the risk of escalation and retaliation. The process of assessment, however, is neither rote nor simple. The unexpected disclosure of abuse coupled with clients' reactivity and fear requires the therapist to shift from the following protocol at a moment's notice and to insure that the shift does not contribute to the woman's risk.

It is best to structure the assessment by holding one couples meeting where a conventional relationship assessment is done, but without in-depth inquiry about domestic violence. Following this, an individual meeting is scheduled with each spouse by explaining that this is a standard procedure that allows each person to tell his or her story without interruption. This increases the likelihood of disclosure of battering (Brown & O'Leary, 1997; Vivian & Heyman, 1996). Initially, this may feel awkward for therapists unaccustomed to shifting between individual and couples meetings who may also run the risk of too heavy-handed a focus on the possibility of domestic violence. With practice, however, a domestic violence assessment can easily be interwoven with the collection of a broad range of clinical information in a natural way. Remember that the initial discomfort is preferable to not knowing information that may be critical to therapeutic planning.

The Initial Couples Meeting

In the first couples meeting, the therapist should not question whether domestic violence occurs, since the potential danger of that conversation cannot be assessed until more information is gathered about the individuals and their relationship. It is critical to treat the disclosure of domestic violence with great care since uncovering physical abuse can provoke retaliatory assault. Instead, as a standard initial interview begins, the therapist begins to collect information that is retrospectively important once domestic violence is identified. Relationship dimensions that should be explored include evidence of affection and reciprocity (Lipchik, 1991), marital satisfaction and adequate functioning in certain marital areas (Lipchik et al., 1997; Shamai, 1996), the mutual capacity for empathy and insight (Lipchik, 1991; Vivian & Heyman, 1996), shared commitment to the relationship, and periods where the balance of control is acceptable to both spouses (Lipchik et al., 1997). If there is no spontaneous disclosure of physical abuse, the clinician can proceed to individual sessions as described below. This can be accomplished simply by saying: "My usual procedure is to have an individual meeting with each person. This gives me a chance to get each person's view of things without interruption and to listen carefully while this happens. We can all meet together afterward and we can discuss whether this kind of therapy can meet your needs."

Individual Meetings

When couples have completed the initial couples interview and there has been no spontaneous disclosure of physical abuse, individual sessions with each person are held in which a more detailed assessment of domestic violence is completed. This is the core of the universal screening procedure. Part of the interviews follow standard procedures to obtain information on mood disorders, family-of-origin history, life stressors, substance abuse, social supports, and past experiences with therapy. Although the individual interviews with the man and the woman share many components, there are important differences between them.

A primary goal in the individual interview with the man is to assess his motivation for change if he discloses violent behavior. This can be accomplished by simply asking "How important is it to you to stop being violent with your partner?" (Saunders, 1992). In this interview, the therapist should be guided by prudence, respect, and concern for accountability. Prudence means avoiding any intervention that could put the partner at risk of retaliation. Respect entails paying attention to the man's behaviors and their harmful effects without labeling him. Concern for accountability denotes an enduring emphasis on the man's responsibility for harmful behavior. It is often helpful to remind him that the therapist is focusing on his actions and does not see him as a bad person. It is helpful to obtain a history of past exposure to family violence, his use of violence in other relationships, the presence of psychosis or severe psychopathology, as well as evidence of organic or physiological factors that may warrant neurological testing (Rosenbaum, Geffner, & Benjamin, 1997; Warnken, Rosenbaum, Fletcher, Hoge, & Adelman, 1997).

In the interview with the woman, it is the ethical duty of the therapist to advise her that no therapy guarantees safety or protection for her and her children and to support her efforts to pursue social and legal remedies in addition to treatment. In this session, the therapist assesses whether the woman is able to choose couples work freely and safely. This includes assessing her degree of depression, her suicide risk, and post-traumatic responses. While exploring the woman's responses to her abuse and her hopes for the relationship, the therapist must also be frank about his or her assessment of the dangerous nature of the situation, with a broad discussion of the variety of ways that treatment of one or both individuals can proceed. It is crucial to address safety planning for the woman and her children, assess her social supports, give her information about shelters and support groups, and, review legal alternatives such as restraining orders. Above all, avoid formulas. Safety plans need to be tailored to the level of risk, the victim's protective resources, and help-seeking capacity. The best strategy is a problem-solving approach where the therapist and the battered woman constantly review risk, evaluate the feasibility and value of different measures of the safety plan, and review her ability or willingness to follow through with the plan. These questions are useful: What have you tried to keep yourself safe? What has worked? Do you think you will be able to carry out this plan? What gets in the way for you? Effective safety planning depends upon the therapist's thorough knowledge of legal protections

and community resources such as shelters, support groups, and legal services for battered women (Cervantes, 1993). Conclude the interview with her by clarifying what information she does not want shared with her partner.

ASSESSMENT OF VIOLENCE AND LETHALITY

In the individual assessment interview, goals are: (1) to learn whether there is any violence between the couple; (2) to ascertain the nature, frequency, severity, and physical consequences of the physical aggression; (3) to elicit detailed behavioral descriptions describing the sequence of events in context; (4) to understand the intended function of the violence and its impact; (5) to evaluate the degree of fear and intimidation present; (6) to determine whether there is a broader pattern of coercion and domination, including psychological abuse and marital rape; (7) to lay the groundwork for an informed decision about the advisability of continued couples work. The following sections will detail how to conduct a violence assessment and how to assess the potential for lethal violence.

Since both partners may have been psychologically or physically aggressive at some point, this inquiry will enable the clinician to make a distinction between isolated incidents of abuse, infrequent mutual abuse, and a pattern involving a primary aggressor and a recipient attempting to defend herself (Cantos, Neidig, & O'Leary, 1994; Cascardi, Langhinrichsen, & Vivian, 1992; Saunders, 1988; Stets & Straus, 1990). The "funnel technique" (Saunders, 1992) is useful to elicit descriptions of psychological, property, physical, and sexual aggression. Rather than employing words like violence, abuse, rape, or battering-which are generally denied by men and women alike-the therapist inquires about specific behaviors, starting with more general questions about marital conflict and then about the less threatening or severe forms of psychological abuse, gradually moving to focus on a continuum of increasingly severe physically aggressive acts. It is also essential to assess the well-being of the children.

Psychological Abuse

The following questions, framed for the woman, can easily be modified for use with the man. Illustrative questions about psychological abuse and coercion include: Does he criticize you constantly? Ignore or interrupt you often? Does he call you names? Swear at you? Humiliate you? Make you ask permission to spend money? Pressure you or prevent you from going to work, school, out to visit friends and family? Is he extremely jealous? Does he accuse you of being unfaithful? How does he deal with anger? Does he yell or scream at you often? Does he frighten you? How? Does he drive recklessly on purpose? Does he threaten suicide? Has he threatened you with violence?

Property Violence

Property violence can be assessed with questions such as: Has he thrown things? Has he broken objects? How? Has he punched walls? Broken doors or windows? Has he

destroyed valued possessions of yours? Has he threatened to hurt pets or actually done so?

Abuse by Man

Moving through the continuum of violence, employ the following questions: Does he push you? Put his hands on you? Restrain you? Hit you with his hands? Punches or slaps? Has he ever hit you with objects? Has he kicked you? Grabbed you by the throat or choked you? Burned you? Cut you? Threatened you with or used a weapon? Has he ever been arrested for assault? Ask the client to describe the first, worst, most recent, and typical incidents of violence. In contrast to eliciting behavioral descriptions of acts, this inquiry is about the context and interactional dynamics of the abuse. At this point, carefully track the sequence of each partner's behaviors. In contrast to earlier interactional formulations, which suggested that the woman could modify her behavior to control the man's violence, the focus here is on assessing the nature of the man's violence while exploring what she is doing to keep herself and her children safe on an ongoing basis. Focus on what happened, where, when, who was present, the extent of injuries, and the perceived goal of the batterer in employing violence. What does she think sets off his violence? Determine whether medical treatment was required, whether criminal justice or legal personnel were involved, the history of restraining orders, and whether one is currently in effect. Explore whether the man's coercion and violence have been escalating or changing in nature. It is important to screen for violence during current or previous pregnancies, a particularly vulnerable and common time for abuse.

Sexual Violence

Screening for sexual violence includes asking: Have you ever had sex when you did not want to? Has he pressured you to have sex or to do things for him sexually that embarrassed or offended you? Have you been forced to perform humiliating or bizarre sexual acts to prove your love? Has he used physical force or the threat of force to have sex with you? Has he had sex with you when you were unconscious or otherwise incapacitated How often has this happened Were you ever injure Have you required medical attention?

Substance Abuse

Empirical research suggests that the correlation between substance abuse and violence is not clear cut (Holtzworth-Munroe et al., 1997). Although more severe and frequent violence is associated with substance abuse (Heyman, O'Leary, & Jouriles, 1995; Pan, Neidig, & O'Leary, 1994), many alcoholics are not batterers and many alcoholic batterers abuse when sober. Following a standard substance abuse assessment with the man and the woman, explore each of their perceptions of the relationship between substance use and violence by asking: Has he ever been violent or threatening while under the influence? Is his violence worse when he has been drinking or doing drugs?

Does he use drugs prior to or after an assault? Have there been violent incidents when he has been sober or clean?

Abuse by Woman

These previous questions can be modified to ask about the woman's aggressive behavior, with special attention paid to who initiated the altercation, why the woman used physical force, whether she or her partner believes she can hurt him, whether either partner takes her physical force seriously, what she has done, the physical consequences of her actions for the man, and whether he is frightened or intimidated by her. Because men report becoming more violent when their partners attempt to use force (Mederos, 1995), it can be helpful to discuss with the woman how she balances her need for retaliation or self-defense with efforts to enhance her safety.

Impact on Children

An essential area of investigation is the impact of domestic violence on children, which can be minimized or unrecognized by both parents. Before entering this discussion with the victim of abuse, it is important to explain mandatory child abuse reporting standards. Therapists need to be familiar with local statutory requirements for reporting to authorities, since events that occurred in the more distant past may not be reportable conditions or some situations may be automatically screened out. Reportable conditions may include neglect, physical abuse, sexual abuse, and emotional abuse/psychological traumatization. Emery and Laumann-Billings suggest that "40% to 75% of children exposed to marital violence are estimated to be victims of physical child abuse also" (1998, p. 125). The therapist should give a brief description of reportable conditions and make clear that she or he will have to provide information to child protection agencies.

A less threatening inquiry (Mederos, 1998) begins by asking about various behavioral signs of trauma children may display: fearfulness, aggression, violence, frequent or prolonged yelling or screaming, depression, withdrawal at home or school, regression, hyperactivity, poor concentration, frequent crying, sleep disturbances, difficulty with separations and transitions, repetitive play, repetitive violent play, intrusive memories, talking often about incidents, startlement (reactivity to noises, sights, scenes), difficulty with age-appropriate impulse control including substance abuse, fear of batterer, engaging in violent relationships, and constant problems with authority figures (Holtzworth-Munroe, Smutzler, Bates, & Sandin, 1996). Once a behavioral baseline has been obtained, the therapist should ask about the following scenarios: Have the children witnessed violence? Obtain a description of the incidents. How does each parent view the impact on the children? Have children intervened in violent incidents? Have they been hurt or injured? How? Sexually abused? Have they been forced or encouraged to participate in violence against their mother? Has the batterer threatened the children with violence or sexual abuse? Have the children disclosed the violence to others? Assumed protective roles with nonviolent parent or siblings? Assaulted the batterer? Walker (1994) suggests investigating the child's developmental history and each

partner's ability to parent: Is the child functioning at age-appropriate developmental levels cognitively, affectively, and behaviorally? How much does each parent depend on the child for emotional support? How does the domestic violence affect his or her ability to parent or to use community resources for help in parenting?

Even if parents deny that children have witnessed or been affected by domestic violence, this inquiry provides an opportunity to discuss the fact that children usually know that violence has occurred even though parents frequently report that children were asleep when incidents occurred. Also, considering the impact on her children may help a battered woman mobilize her self-protective resources. If she provides information that the therapist must report to a child protection agency, it is critical to do safety planning with her, as reporting can heighten risk even as it brings in necessary resources. How does she think the batterer will react? Does she need to leave with the children? Where can she go? If the batterer discloses reportable conditions after notification of mandatory child abuse requirements by the therapist, it may also be important to discuss safety planning with him. Is he likely to react strongly to information provided by his children or spouse? Is there a risk of his assaulting the child protection worker? The therapist must provide the agency with this information. It is also important to inform the partner prior to making a child abuse report based on information provided by the batterer, since this may trigger an assault on his part or be part of a coercive strategy. It is not unusual for the batterer to threaten to have the authorities take the children away to punish his partner or to pressure her to recant about his abuse. If there has been sexual or physical abuse or severe traumatization of children, couples therapy should not be pursued until strict and clear conditions of safety have been established.

Multimodal Assessment

Although the majority of therapists rely on clinical interviews, empirical evidence suggests that written questionnaires may provide the highest detection (Brown & O'Leary, 1997; O'Leary & Murphy, 1992; O'Leary, Vivian, & Malone, 1992). Aldarondo notes, "The combined use of structured instruments and interview assessment yields additional acts of aggression and intimidation and a better understanding of the context for the physical aggression and its consequences than either technique alone" (1998, p. 442). See Aldarondo (1998) and Aldarondo & Straus (1994) for a detailed description of a number of written instruments, including their validity and reliability.

Lethality Assessment and Ethical/Legal Mandates

A central goal of individual meetings is the assessment of the degree of danger and the evaluation of risk markers for life-threatening violence. Additionally, it is an effective way to determine the safety and wisdom of couples therapy. A number of risk markers have been associated with life-threatening violence (for a review, see Aldarondo & Straus, 1994; Campbell, 1995). The prediction of potentially lethal violence is a clinical art and is not accomplished through easy application of a given formula. Although the use of a list of risk markers may lead to the overidentification of men who may be lethal

(Aldarondo & Straus, 1994; Saunders, 1992), it is wise to err on the side of caution. The presence of one of these factors alerts the clinician to the possibility of lethal violence, reinforces heightened monitoring of the situation, and helps the therapist to initiate actions, both legal and social, to strengthen the web of safety for the woman and her children. Urging caution concerning lethality checklists, a prominent social activist and codeveloper of an internationally recognized model of community intervention against domestic violence warns that it is erroneous to mechanically assume that a greater number of risk factors means greater danger: "abusive behavior [defies] prediction based on a formula" (Pence, 1996, p. 163). Often, a sufficient indicator of a man's potential for lethal violence, even in the absence of other risk factors, is the woman's sense that he will likely seriously injure or kill her. It is important to keep in mind that some highly traumatized women may minimize danger.

With this as a caveat, the lethality assessment directs inquiry to seven risk factors:

Substance abuse. Current or unresolved periodic substance abuse makes violent behavior even more unpredictable and more subject to sudden escalation.

History of violence. Causing physical injury to women or children, two or more acts of violence in the last 12 months, or a history of marital rape.

History of violent crimes and previous violations of restraining orders. This includes convictions and/or accusations of assault on spouses or nonfamily members.

Use of weapons. Prior history of the threat or use of weapons, including the use or threat of martial arts or other similar training, indicates increased risk of serious harm. It is essential to ask about the availability of weapons once domestic violence has been identified.

Threats. Read threats as statements of future intentions to retaliate, hurt, or kill the woman and/or self.

Obsession with partner. Many men who kill or severely injure their partners are obsessed with them. Because of profound attachment insecurity, they cannot accept the woman's autonomy or differentiation. Obsessional behaviors includes intense jealousy, repeated accusations of infidelity, ongoing suspicious monitoring of the woman, calling her often to check her whereabouts, jealously isolating, stalking or harassing the woman at work, and severely limiting her contact with people. If the woman is threatening separation, lethality potential must be even more closely monitored.

Bizarre forms of violence. Men with profoundly limited empathy for their partners may employ severe abuse that has sadistic or depersonalized aspects and takes on elements of torture such as deliberately hurtful rape, burning, starvation, and sleep deprivation.

The presence of a single risk factor for lethality rules out couples work, even when previous physical abuse has been absent or minimal. This last point is critical. In addition, clinical experience suggests there are two types of batterers that are particularly dangerous, each of which constitute one-quarter of batterer samples (Aldarondo, 1998; Eisikovits & Edleson, 1989; Holtzworth-Munroe et al., 1997). The dysphoric/borderline batterer is characterized by compromised attachment issues, inability to trust, some paranoia and/or pathological jealousy, and borderline or schizoid features. The generally violent/antisocial type is violent to many people, often has an extensive criminal record, and experiences violence as ego syntonic. Batterers who fit these profiles should be even more carefully assessed for the risk markers outlined above, and couples treatment is contraindicated (See Berns, Jacobson, & Gottman, this issue).

A lethality assessment often has ethical ramifications. There is the legal duty to warn potential victims and criminal justice personnel if a person states that he or she is going to commit an act of violence against another (Cervantes, 1993; Cervantes & Hansen, 1997; Hart, 1993; Sonkin & Ellison, 1986; Willbach, 1989). This is an "imminent danger" warning. In addition, in cases involving domestic violence, the therapist should tell the partner if the batterer appears extremely dangerous or lethal. Though this information may not be new for a partner, receiving this warning from a professional may help activate selfprotective resources.

It is appropriate to ask the battered woman about the risk of her lethally retaliating against her abuser. The following questions are useful: (1) Do you feel you have no other option but to take action yourself? (2) Are you feeling desperate? (3) Have you thought of or attempted suicide? (4) Do you have a plan? These questions are critical when she has been severely injured or been frequently physically and/or sexually assaulted and when the man is frequently intoxicated or high or has established overwhelming control (Browne, 1987; Campbell, 1995). This information should lead to a discussion of safety planning and alternatives to harming oneself or others as outlined above.

ASSESSING THE FEASIBILITY OF COUPLES WORK

Following the couples session and individual meetings with each person, the clinician now decides whether the nature and consequences of the domestic violence suggest that couples therapy can be employed safely and effectively. It is important that the therapist not be bullied into couples work because the male client says he will only attend couples therapy. The decision to attempt couples therapy also rests on more than the woman's desire to do so. If the therapist assesses the situation as too volatile or dangerous or the victim of abuse as too vulnerable as a consequence of the violence, this is important information for the woman. A protective stance requires that couples therapy not be utilized unless rigorous criteria have been met and all have agreed to specific parameters of the treatment contract.

Criteria for Initiating Couples Work

The essential prerequisite for couples therapy is that both spouses freely agree to couples counseling. Care must be taken not to pressure the woman into couples work. Sometimes when the couple meets criteria for low-risk couples therapy, the woman prefers to obtain support and explore resources elsewhere. Support her autonomy and efforts at seeking professional or other help on her own. Second, couples therapy can be considered if the man's violence is limited to few incidents of minor violence, such as slaps, shoves, grabbing, and restraining, without resulting bruising or injury. This guards against the cumulative effect of repeated mild violence that can negatively influence the process of therapy in a decisive manner. Third, the man's use of psychological abuse is infrequent and mild (Aldarondo, 1996; Murphy & O'Leary, 1989; Vivian & LanghinrichsenRohling, 1997), does not create a climate of constant anger or intimidation, and is neither terrifying nor debilitating to the woman. This excludes cases with mild to moderate violence but with severe psychological abuse. Fourth, no risk factors for lethality are present and the woman is not fearful of retaliation. This screens out men who might escalate rapidly toward violence, even in the absence of severe physical abuse and so may be less amenable to couples work.

Fifth, the man admits and takes responsibility for his abusive behavior. All members of the therapy system must work within an explicit and clearly articulated framework of who is responsible for the abuse. Couples work is contraindicated if the man expresses no remorse, denies his actions, only blames the woman, and has little commitment to change. Similarly, if the woman's fear is high and if she blames only herself or feels she deserved maltreatment, individual or group work is recommended. Finally, the man must demonstrate an ongoing commitment to contain his explosive feelings without blaming others or acting them out, so that they do not provide a launching pad for a relapse of violent behavior during the course of treatment. This is an essential prerequisite to engaging in the intense work of marital therapy with safety. It is diagnostic whether the male client is willing to agree to these conditions. If he is not, it suggests that he does not understand the terrorizing qualities of his violence nor his sole responsibility for his actions. Under these conditions, couples therapy is not a protected setting for the woman and should not be pursued. Furthermore, the batterer must agree to surrender weapons for the duration of treatment to the local police department (Saunders, 1992).

An additional criterion applies when bidirectional violence has been identified. Couples therapy may also be considered in cases where there is bidirectional violence that is mild, infrequent, and has resulted in no bruising or injury. It should be kept in mind that even in these cases wives report more negative psychological impact than husbands as a result of bidirectional violence, which suggests that the impact of violence and psychological abuse must always be assessed carefully in light of its gender-specific context (Vivian & Langhinrichsen-Rohling, 1997). Thus, when there is bidirectional violence, an additional condition of couples work is that the man recognizes that his

violence has greater effects than does his wife's and is able to accept an asymmetrical focus in the couples therapy (Vivian & Heyman, 1996).

Parameters of the Therapy Contract

Since the therapist can provide only relative safety for the woman and her children, it is important to construct a therapeutic contract that sets clear limits on psychological and physical aggression, with agreed-upon consequences if those limits are breached. Both spouses must agree that the primary goals of therapy are ending the man's psychological and physical abuse and facilitating the woman's repair and recovery from his violence in order to establish a reliable and tested climate of safety in the relationship. Written nonviolence contracts are often helpful (Gutsche & Murray, 1991). In addition, couples work should not proceed once domestic violence is identified when spouses in treatment are unable to have a relatively controlled and respectful conversation about delicate subjects, when either spouse's anger is unmanageable, when offensive or intimidating language is used and not tempered by the partner's response or therapist intervention, and when there is evidence of ongoing intimidation or coercive control (Vivian & Heyman, 1996).

There must be shared agreement on the consequences for the couples work should there be another violent incident. On this latter point, therapists are divided. While many recommend ceasing couples work until a violence-free period has been accomplished for 6 months or more, others do not. While recognizing that disagreements about clinical preferences are legitimate and valuable, it must be emphasized that the most protective measures are ethically and morally necessary. Thus, we recommend that couples therapy cease and the man enter a specialized batterers' intervention program if he is violent or intimidating while in conjoint treatment.

MANAGEMENT OF ALTERNATIVE SCENARIOS

The previous assessment protocol presupposed that domestic violence was not disclosed in the initial telephone intake or in the first couples interview. However, a potentially explosive disclosure can occur well before the clinician has created protected conditions. Clinical responses and management of risk vary depending upon the timing and nature of the disclosure. Because of this, two commonly encountered contingencies are described and possible interventions summarized concerning: (1) disclosure of violence prior to the first couples meeting; and (2) spontaneous disclosure in the couples meeting.

Violence Disclosed before Couples Meeting

Sometimes a client will volunteer information about domestic violence in a phone call. Many agencies are training intake workers to ask about domestic violence in brief early contacts with clients seeking treatment. In such telephone contacts, it is important to inquire about the nature of the violence. If it appears that it is severe or moderate but

frequent, or if there is reasonable fear of retaliation, it is best to begin by interviewing the woman individually to assess her partner's dangerousness and to clarify that couples work will not be productive or safe if the risk is excessive. Explore options for her individual therapy as well as referrals to other resources. Also, discuss whether it makes sense to focus first on her safety rather than addressing the man directly about his violent behavior.

If she reports that the violence is moderate and infrequent and that the risk of retaliation is low, schedule an initial couples meeting but delay a substantive discussion of violence until the individual meetings and then follow the protocol outlined above.

Disclosure of Violence in Couples Meeting

When violence is spontaneously brought up by either spouse in the couples meeting, the discussion can proceed in two directions, depending upon the severity of the violence that has been disclosed. If the violence has been moderate and there is reduced concern of serious injury, the therapist should use the meeting to make an initial safety intervention with the man and to create protected conditions for further disclosure in the individual meetings. This initial safety intervention involves setting limits with the offender through a firm agreement about his refraining from further use of force or intimidation. Concrete steps are offered to support his follow-through on this agreement, such as the standard strategy of timeout. This technique calls for the man to monitor himself and note his internal warning signals as he escalates toward an assault and to interrupt his cycle by going out for 15 minutes or longer to calm himself. The woman can be asked if she is willing to cooperate with this strategy. The man's unwillingness to employ timeouts at this point is an early contraindication for couples work. If there is agreement about following a timeout procedure, explore situations in which his violence is likely to escalate, so that he takes more responsibility for self-monitoring. The clinician can then proceed to the individual sessions, emphasizing as above that this is the usual procedure, but also adding: "Now that you've told me that there has been some violent behavior I want to be even more careful not to make things worse, so I want to be sure that I understand where each of you is coming from before we proceed." How a couple handles the disclosure provides significant information about the feasibility of couples therapy.

In contrast, if the spontaneous disclosure in the initial couples session indicates that the man has been severely violent recently and there is concern about escalation, the focus on safety intensifies. If the woman has disclosed the violence, the man may be caught off guard or may feel betrayed. It is imperative to assess immediately whether it is safe to continue discussing this topic: "Is this the first time the two of you have discussed this with someone else? Did you agree to talk about this beforehand?" If the woman seems to be endangering herself by disclosure, inquire, "What's going to happen when you walk out the door in an hour? How will the two of you keep things safe?" Begin problem-solving with regard to safety with each person. In general, the woman's safety plans are not discussed in front of the man. However, under these circumstances, it is often

unsafe to ask the man to leave the session. Some batterers cannot tolerate this, as it heightens their anger, suspiciousness, and fears of abandonment and loss of control. If possible, it is important to request that the man be specific about his plans, while questions can be posed in ways that attempt to keep the woman's plans more ambiguous, should she need to seek safe refuge. The woman's safety plan should always address alternatives for her to pursue if her partner does not follow his safety plan. At this point, couples therapy is contraindicated, although efforts are made to engage both spouses in therapy. Though this predicament is unusual, it illustrates the gripping immediacy of clinical intervention with batterers and their partners.

If the batterer has made the disclosure of severe violence or agrees and/or expands upon his partner's disclosure, then it is possible to engage in a more substantial intervention to promote safety and attempt to forestall a slide into a violent retaliation as a result of an early disclosure. In keeping with a stance that focuses on his behaviors and their harmful effects while presenting him with suggestions for safety that are strategically framed for his self-interest, say: "I'm really worried about what you just told me. If you hurt your partner seriously you will destroy your relationship and you may end up getting the police after you. Have you thought about this?" If he blames his partner for his conduct, add: "The problem is that intense things happen in relationships. These things will happen again. I would like to help you, but it would take your agreeing to react in a different way. No one can make you do that. I can hear that you feel she makes you do things, but my job is to tell you the truth as I see it. If you go after her, you will be destroying someone you love. You don't have to get violent when you feel a certain way."

If his partner reacts by defending him, agree that he is not a terrible person or that she may have behaved in ways that anger him, but state that he has to be prepared to react in a different way: "If he hurts you he will make things worse for both of you. Our society will hold him responsible no matter what else happens." The focus on safety should continue with: "Can we talk about what gets you going and what you can do with yourself to react in a different way?" This is an attempt to elicit self-reflective awareness of triggers for violent behavior and to have him visualize nonviolent alternative responses. He may deny that there are alternatives, which can be answered with "There are probably hundreds of other things you could have done. Let's just think of one or two." This helps the batterer undo his rationale that his violent behavior is involuntary or unavoidable. It is important to ask him gently and persistently to do this visualization.

It is appropriate to state early in this process that couples therapy is contraindicated. "I know you want to do couples counseling, but things are pretty intense right now and we often find that when things are so hot, couples therapy makes problems worse. A lot of guys feel more provoked and blow up. I would be lying to you or misleading you if I told you this could work now." An immediate referral to a batterers' intervention program is in order: "Now that I have a better sense of what has happened, I think that you should follow up with help for yourself. This kind of therapy will not meet your needs." Supportive statements can be made indirectly to the woman by addressing the man:

"Joe, you should realize that when you behave like this you drive people away. It creates fear. The use of force is not justified in family relationships even if you feel justified. No one deserves to be hit and no one should have to earn the right to be free of violence." These simple statements can prove enormously encouraging to a battered woman, particularly if she is isolated. Even if this encounter is not followed up by subsequent clinical engagement, it may support a woman's growing sense that she is not at fault for what has happened.

In the context of a situation where severe violence has been reported and the batterer cannot respond to these invitations to responsibility (Jenkins, 1990), acknowledge that his refusal to take corrective action will have consequences: "I am concerned about where things will go. You have talked about some violent behaviors that concern me. Have you thought that you might really hurt her? Or even kill her? What would your life be like if you did something really terrible? I am very worried about you and your spouse." This is an apt way to issue an indirect severe danger warning in the rare situations where it may be too hazardous to address the partner directly because the batterer is present. In acute situations, the clinician should limit empathic responses to the partner to avoid his retaliating against her later. Instead of saying to her "That sounds awful" or "How did that make you feel?" one can say to him, "When I hear that it sounds really frightening. Were you trying to hurt her or terrify her?" It is important to indirectly remind her that she will remain in danger, despite his having come to counseling.

Conflicting Reports of Violence in Individual Meetings

Situations exist where the battered woman has disclosed severe violence by her spouse and asked that this information be kept confidential, while the spouse has categorically denied domestic violence in the individual interview. This predicament deserves careful attention because the clinician should decline to provide couples therapy, but may be prevented from doing so or disclosing reasons for this decision because of protective confidentiality. The most protective path is to recommend individual therapy for both partners based on credible reasons derived from case information that does not bring in the partner's disclosure of domestic violence.

If the woman discloses violence in a private contact and is unwilling to address the man's abuse with him but wants the therapist to be aware of it, it is often helpful to meet with her alone to explore her reticence and to explain that it is ultimately impossible to do good couples work without addressing such a central issue. In some cases, the man refuses to come to therapy unless it is with his partner. This poses a dilemma for the therapist if there has been significant abuse. While some therapists refuse to see couples at this point, this can result in the couple not seeking any therapy, further isolating the woman. Thus, it is sometimes necessary to meet with the couple together, in order to see if enough of an alliance can be achieved to shift to the safer assessment context of individual meetings.

CAUTIONS

This beginning effort to conceptualize and formalize a domestic violence assessment protocol for marital and family therapists is accompanied by cautions concerning the false sense of security it may provide and questions about the advisability of couples therapy.

False Sense of Security

It is our opinion that a universal screening process is far preferable to the more common practice of no inquiry. But even the protocol outlined here runs the danger of creating a false sense of security. The assessment of domestic violence is neither simple nor completed in a discrete set of interviews. While structured assessments increase the likelihood of identifying domestic violence, they do not guarantee it. Even when domestic violence is identified, its extent and consequences are often minimized or suppressed. Estimating risk or lethality is at best a calculated opinion, never a certainty. The meaning and impact of domestic violence must be assessed dynamically by understanding the experience of the woman, rather than statically through simple scales. For example, a minor incident a decade ago may permanently have shifted the balance of power in the couple. Thus, even when domestic violence is not identified in an initial assessment, therapists should never assume it does not exist and must remain sensitive to clues that may suggest its presence, such as one partner's consistent refusal to challenge the other or having one partner consistently answer questions or speak for the other. Even when domestic violence has been identified and the therapist and couple believe couples work is possible, it is important to remain alert to the possibility that the violence is still occurring or is more serious than initially described.

The Advisability of Couples Therapy

It is important for the therapist to provide a rationale for couples work, especially when alternative models are available. Many battered women are helped less by therapy than by participation in profeminist support groups geared to expert safety planning and the creation of a supportive network with friends, relatives, and other group members. Many batterers, even those who would be appropriate for couples therapy according to this protocol, would benefit more directly from specialized men's groups for offenders, where the risk of retaliation against a partner is further minimized (See Almeida and Durkin, this issue). The assessment protocol presented here does not guarantee a safe intervention; it guarantees a safer intervention than has been previously outlined in detail, and it requires therapists to be thoughtful in an ongoing way about how safety and protection issues are being conceptualized and addressed. Because it requires considerable clinical skills to manage the moment-to-moment decisions about danger, the intense volatility of some conjoint meetings, and the personal reactions of the therapist, we strongly recommend that only experienced therapists experiment with couples therapy given that the risks are not all known.

CONCLUSIONS

Ideally, the assessment of couples for domestic violence should be a part of every intake interview. Identifying those who may not be appropriate for couples therapy at intake creates a safer context for couples work for those who meet the criteria, while establishing an ethical and protected setting for marital and family therapists to explore the efficacy and wisdom of couples work for some batterers and their families. It is critical that decisions about couples work be based not on faith or familiarity with couples therapy as a therapeutic modality but on concrete data obtained from the couple and on the detailed knowledge of risk assessment and the intricate dynamics of violent relationships (Brown & O'Leary, 1997; Vivian & Heyman, 1996). At present, the majority of states have public policy regulations that delay couples therapy for court mandated batterers until participation in a specialized program, a 6-month period of nonviolence, and the woman's full consent and willingness to be seen in couples therapy. In some states, however, there is the possibility that couples work may be court-mandated (E. Gondolf, personal communication, July 3, 1997). This reinforces the need for every marital and family therapist to develop a proficiency in this clinical specialty and to clarify one's ethical and clinical positions about the significant risks of couples work.

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