Chapter 7

The Uniqueness of Mental Health Practice in the Intimate Partner Violence Domain

Chapter 7 describes how the intersection between the mental health and justice systems brings with it unique roles and responsibilities for mental health professionals, who must be attuned to the safety of clients, and cognizant of how standards of conduct typically applied to clinical practice may change in this area of work. An expanded view of who the client is and the need to work in teams rather than individual clinical practice are examples of how clinical practice can change. Chapter 7 also describes common pitfalls encountered by clinicians in these cases, particularly as they relate to assessment, confidentiality and the management of client records, roles in court, boundary issues, and the misapplication of common clinical modalities. Finally, the chapter explores the phenomenon of “secondary traumatization”—the negative impact that clinical work in the intimate partner violence domain can have on a clinician. The sections within chapter 7 include:

- The integration of mental health practice in the criminal justice system
- Common pitfalls encountered by clinicians in cases of violence against women
- The impact of helping: secondary traumatization
THE INTEGRATION OF MENTAL HEALTH PRACTICE IN THE CRIMINAL JUSTICE SYSTEM

By definition, intimate partner violence is criminal conduct that results in harm to a targeted person. As a result, clinicians who treat victims or offenders or who specialize in the psychological impact of trauma may find their practice intersecting with the criminal or civil justice systems. The point of intersection between the mental health and justice systems brings with it unique roles for clinicians. They must be attuned to the safety of clients and understand how standards of practice typically applied in routine clinical practice may change in application to these cases.

For example, clinicians who assess and treat offenders must take a broader view of who their client is than do typical clinicians. In addition to providing services to offenders, treating clinicians are often required to submit evaluative or progress reports to a court, a practice that in many states alters the application of laws related to confidentiality or privileged communication. Specifically, when an offender has been informed that the assessment or evaluation is for the court (i.e., when it is court ordered or court mandated), confidentiality laws related to the offender’s disclosures in that limited setting are no longer applicable. Under this circumstance, the court has not become the client (in the strictest sense), but the obligation the clinician has of preparing reports for a judge who has mandated a client into treatment changes the nature of a therapy relationship with the offender-client. In addition, clinicians treating offenders are encouraged to define “client” in broad terms by maintaining a vigilant awareness of the degree to which the offender poses a risk of harm to the victim. Again, the victim is not a client in the strictest sense if the clinician is working with the offender, but the clinician incurs a legal and moral responsibility to attend to her safety when treating an offender. The duty to warn or take steps to protect intended victims from harm (discussed in chapter 6) is consistent with this broader view.

In addition to expanding the definition of “client,” practice in the intimate partner violence domain also means clinicians may need to expand the number of professionals with whom they have contact on any given case. Over the past decade, professionals working in the intimate partner violence field have moved to a model of multidisciplinary team approaches, replacing single agency or clini-
Uniqueness of Mental Health Practice

Cian interventions. This model has afforded communities the opportunity to develop effective criminal justice responses to the investigation, prosecution, and treatment of intimate partner violence.

In addition to providing direct mental health services to a victim or offender, as a result, clinicians may also be asked to participate in multidisciplinary teams related to the management of interpersonal violence cases. Multidisciplinary teams, sometimes termed “coordinating councils,” operate differently across the country. They may address policy and program development and the organization of protection and court services in a local community, and they may also engage in case-management functions. To the extent that a clinician participates in the latter, it is important to seek appropriate releases of information from clients before discussing any case within the context of a team setting. Clinicians who treat offenders may be excluded from case management teams, as these groups are often centered around the investigation and prosecution of a case and therefore would pose a conflict of interest to a clinician treating the offending client about whom the team was meeting.

Mental health professionals can offer unique expertise to the effective operation of multidisciplinary teams. These contributions may include the following:

- assisting a prosecutor’s office in preparing a victim or the victim’s children for participation in court proceedings,
- providing consultation to criminal justice professionals investigating or prosecuting intimate partner violence, (e.g., assessing the risk posed by offenders or interpreting the behaviors of victims within the context of trauma response), and
- participating with team members in needs assessments and the development of adequate offender treatment and victim support services within the community.

COMMON PITFALLS ENCOUNTERED BY CLINICIANS IN INTIMATE PARTNER VIOLENCE CASES

In addition to altering clinical practice, working with victims or offenders of intimate partner violence exposes clinicians to certain pitfalls, several of which are described here.
Common Pitfalls Faced by Mental Health Professionals

- Practice outside the boundaries of competence
- Failure to assess intimate partner violence
- Over- and underreactions to client disclosures of victimization
- Loss of client privacy by introducing clinical records in court cases
- Blurred boundaries for clinicians in the courtroom
- Overreach by clinicians testifying in court
- Overreliance on syndromal labels
- Cautions about individual psychotherapy with intimate partner violence offenders
- Cautions about marital or couples therapy
- Cautions about alcohol- and drug-abuse counseling
- Cautions about pastoral or Christian counseling

Practice Outside the Boundaries of Competence

Traditional clinical training programs have not typically included intimate partner violence in a significant way within graduate curricula. As a result, substantial numbers of clinicians enter into practice without sufficient preparation to intervene appropriately with intimate partner violence victims or offenders. Lack of graduate preparation leaves a clinician vulnerable to pitfalls resulting from practicing outside the boundaries of competence. The admonishment to psychologists found in the ethical standards of the profession is good advice to all mental health professionals: “In delivering services to clients or patients, psychologists must always be mindful that a primary obligation is to function competently. When providing services outside of one’s area of competence, the risk of harm increases significantly” (Canter, Bennett, Jones, & Nagy, 1994, p. 34). The ethical standards go on to advise that simply having an “interest” in a particular area of clinical work does not necessarily qualify one to deliver services effectively or safely.

As discussed in chapter 6, it is recommended that clinicians identify victimization through abuse-specific screening; engage in competent risk assessment; and refer clients appropriately if treating intimate partner violence is not a primary area of expertise. If a
clinician wishes to develop a specialty practice with victims or offenders, reading journal articles that provide findings from research studies or reviews of areas of the literature on intimate partner violence, attending didactic training programs on the roles and responsibilities of mental health professionals in these cases, and receiving clinical supervision from a professional skilled in this specialty area are recommended. Clinicians wishing to build this specialty practice are also encouraged to visit local domestic violence shelters to become familiar with the services of the programs and the important perspective that victim advocates can offer to work in the intimate partner violence domain. In addition, to ensure effective practice, specialty clinicians should be knowledgeable about applicable laws in these cases (e.g., civil protective orders, mandatory reporting laws).

FAILURE TO ASSESS INTIMATE PARTNER VIOLENCE

As discussed in chapter 6, the presence of victimization history among a substantial number of women who seek mental health care is well documented. It does not follow, however, that clinicians routinely screen for abuse, nor that they detect abuse when working with clients (Jordan & Walker, 1994; Saunders et al., 1989). If a clinician is unaware of a client’s exposure to violence, accurate lethality assessment will not be possible. In addition, if existing abuse is undetected, the clinician will also be unable to address a substantial factor effecting the client’s mental health. Finally, undetected intimate partner violence leaves the clinician in the position of structuring a treatment intervention that could actually increase risk of harm to the client. A reasonable standard of care to avoid these pitfalls is to assess intimate partner violence among all female clients.

From the legal point of view, the failure of a clinician to inquire, and to document the inquiry, about intimate partner violence can be cause for a finding of negligence just as it might be with unassessed suicidality. While not every clinician is expected to be a specialist in the treatment of intimate partner violence, concerns regarding client risk and clinician liability mean that the clinician should be able to assess the likelihood of this problem so that an appropriate referral can be made.
OVER AND UNDER-REACTIONS TO CLIENT DISCLOSURES OF VICTIMIZATION

Both novice and experienced clinicians will be exposed to clients’ disclosures of graphic and severe victimization experiences. The challenge for clinicians in this circumstance is to respond in a balanced way that encourages the client to continue to disclose information at whatever level is needed. As a caring human being, it would be easy for a clinician to overreact with horror to a client’s disclosure of her victimization. To do so, however, could communicate to the client that the clinician is threatened by such information and must be shielded from further disclosure. An overly emotional response could also elevate the client’s existing level of fear regarding her circumstances; or it could leave her feeling more isolated and cause her to feel ashamed to reach out for assistance. At the other extreme, a completely unempathetic or matter-of-fact response to a client’s disclosure could convey lack of caring and reinforce the tendency to minimize or deny victimization experience that is common to many victims. The challenge for the clinician is to strike a balance by communicating concern, care, and openness to further the exploration of the client’s experience. The clinician should not suppress or deny honest human reactions to disclosures of human violence and cruelty. In fact, as will be discussed later, clinicians are encouraged to be aware of their own experience to hearing trauma stories from clients, including anger, fear, disgust, detachment, or other reactions, but should do so through discussion with supportive colleagues or supervisors outside the clinical setting. A similar balance must be achieved for clinicians learning of violence perpetration from a client. In this case, clinicians need to encourage disclosure from an offending client while remaining clear that violence is not appropriate behavior.

A second common pitfall for clinicians upon learning of current abuse from a client is to advise the client how she or he should behave. It is understandable that a therapist might want to urge a client to leave an abusive relationship immediately, divorce the violent partner, or to file criminal charges, but clinicians must be alert that doing so may encourage unsafe choices by a client. Feeling pressured by the clinician’s advice, a client may act to seek an arrest warrant, for example, and may take that step before she has had adequate opportunity to take steps to be safe from offender retalia-
tion (e.g., prepare a safety plan, move to a shelter, seek a protective
order). Clinicians should also be sensitive to the fact that making
choices for a client who has been victimized by an intimate partner
is a form of taking control that reinforces one of the aspects of the
abusive relationship. At the point of disclosure, the clinician should
discuss all available sources of protection with a victim and ensure
that she understands all that is available to her and can access what
she wishes. The clinician should not convey that a particular solution
is the only one appropriate for her.

LOSS OF CLIENT PRIVACY BY INTRODUCING CLIENT INFORMATION IN COURT CASES

Clinicians can also encounter pitfalls if they are not fully sensitive
to the confidentiality of victim statements and the impact of mental
health records being introduced in a court proceeding. Offenders
may attempt, in both civil and criminal proceedings, to access privi-
leged information found in mental health records of a victim (MUR-
PHY, 1998), and some have suggested that clients with victimization
histories are among the most likely to have their records subpoenaed
for legal proceedings (HAMBY, 2004). Standardized releases of infor-
mation may not adequately prepare a victim for the effect of having
private information (including the mental health effects of her victim-
ization or prior abuse history) revealed in court. At a very basic
level, the release of a record in court may provide the defense with
information such as a new residence or address for a victim, the
very detail she most needs to conceal from the offender to ensure
her safety. In addition, a defense attorney may seek evidence that
a victim has suffered prior abuse as a means of discounting the
victim’s current claim of violence. In a domestic action, opposing
counsel may seek evidence of substance abuse or depression in a
victim to prove unfitness as a parent. Of course, clinicians should
attempt to protect the confidentiality of a client’s records, but if
records have been subpoenaed or will be introduced in the court
proceeding, the clinician must ensure that the victim is fully pre-
pared for the ramifications associated with the loss of her privacy.

In order to fully inform clients regarding the circumstances under
which their records could be turned over to a court, and to ensure
ethical and legal clinical practice, clinicians should become informed
of differences between subpoenas and court orders related to the release of records and guide their actions accordingly. For example, a subpoena is an order of the court for a witness to appear at a particular time and place to testify. (If the subpoena also requires the production of records that are in the control of the witness, it is called a “subpoena duces tecum”). A subpoena is the method used by parties in a case to obtain testimony from a witness at both depositions (where testimony under oath is taken outside of court) and at trial. Subpoenas are usually issued automatically by the court clerk upon the request of one of the parties, and they are issued prior to a hearing at which the opposing side has the opportunity to raise objections to the judge about the records being produced. If it is the view of the clinician that testimony or the production of records is not in the best interest of the client, a “motion to quash” the subpoena may be filed with the court. Upon hearing the evidence at a hearing, the court will then determine whether the testimony or records are relevant and therefore should be turned over; or whether there is not sufficient relevance or the privacy interests of the client outweigh the benefit of the materials being introduced in court. Clinicians may also request that only a particular portion of a record be turned over to the opposing counsel, and may ask that the judge conduct an in camera (out of the courtroom) review before rendering an opinion regarding the relevance of the records to the court proceeding. Specific court procedures related to records and other evidence are set out in laws and court rules specific to the state or jurisdiction in which the clinician practices and should be referenced as a guide to ethical and legal practice.

**Blurred Boundaries for Clinicians in the Courtroom**

A second potential court-related pitfall for clinicians is the blurring of boundaries regarding their clinical relationship with an individual client and their testimony as an expert on intimate partner violence or trauma. Clinicians should be absolutely clear with clients, and with the attorney who seeks their testimony, regarding that role they are playing. If a clinician is subpoenaed to testify in court, it is important to distinguish the role of expert from treating clinician. A clinician who is treating a victim or offender should not, in most instances, be the clinician providing expert witness testimony on
intimate partner violence, posttrauma response, or other matters. There is a potential conflict inherent in these roles, as the treating clinician may not be objective. In addition, testimony as an expert may result in comments made that are not in the best interest of the client or, at a minimum, that compromise the therapeutic relationship. Clinicians should be guided by the ethical standards of practice for their professions to protect both their own practice and the well being of a client. For example, the ethical standards for psychologists proscribe conflicting roles: “In most circumstances, psychologists avoid performing multiple and potentially conflicting roles in forensic matters” (Canter, Bennett, Jones, & Nagy, 1994, p. 150).

**OVERREACH BY CLINICIANS TESTIFYING IN COURT**

Clinicians who testify in court are often encouraged to provide testimony beyond their level of expertise. This may include being asked by a prosecutor or defense attorney to testify about the topic of intimate partner violence when that is not the clinician’s specialty area of practice or when the clinician does not have a working command of the research literature in this area. While the clinician may be expert in trauma or forensic psychology, if they do not have a detailed working knowledge of intimate partner violence, they are advised to decline to serve as an expert or to clearly communicate the boundaries of their expertise to the defense counsel or prosecutor. As will be discussed in the following section on syndromal labels, even evaluating clinicians who are expert in intimate partner violence may also be at risk for such overreach if they testify that violence did not occur because they do not see specific evidence in the demeanor or mental status of the victim. As detailed in chapter 4, victims’ reactions to physical, sexual, and psychological maltreatment vary based on numerous internal and external factors, and clinicians are cautioned regarding offering their expert opinion until they are fully informed regarding those influences. It would also be an overreach to testify that a client’s current mental health problems relate to their prior victimization history instead of to a current rape, for example. This is something that may be asked of a clinician by defense counsel.

Finally, clinicians should also be cautious about testifying as an expert if they have only interviewed one of the parties to a case. This
Intimate Partner Violence is a common pitfall in custody evaluations where intimate partner violence has occurred between the parents. There is evidence that custody evaluators are not equally skilled in evaluating for the presence of intimate partner violence and do not always ensure that the detection of abuse informs their recommendations to the court (Logan, Walker, Jordan, & Horvath, 2002). Effective expert testimony regarding the custody of a child requires evaluation of all parties and a specific determination regarding the impact of witnessing violence on the child for whom custody or visitation is being sought (see chapter 7).

**RELIANCE ON SYNDROMAL LABELS**

The psychological effects of violence against women have been described through development of two specific syndromes. Development of the Battered Woman Syndrome (BWS) provided a construct for beginning to understand the psychological effects of intimate partner violence (Walker, 1984, 1991). BWS was developed out of interviews with 435 women suffering from intimate partner victimization and was in part intended to redirect focus from the internal personality features of battered women to the external factor of violence that elicits psychological responses. This contextualization of a woman’s emotional, cognitive and behavior reactions was viewed as less stigmatizing and victim-blaming and helped create an understanding that victimization experiences were the cause, not the result, of mental health problems for a woman (Koss et al., 1994). In the early 1970s, Burgess and Holstrom (1974) organized what they viewed to be common reactions of rape victims in a two-phase model consisting of an “acute” stage immediately following the rape, and a second, “reorganizational” phase evidenced in variable symptoms occurring in the months following. This second syndrome, named the rape trauma syndrome (RTS) originated from a study of 146 rape victims and was initially developed to assist therapists and advocates to structure their intervention with a victim following the rape. Its development was groundbreaking in characterizing a woman’s reactions to rape and in providing a catalyst for future controlled empirical studies with rape victims (Frazier & Borgida, 1985; Boeschen, Sales, & Koss, 1998).

While development of the two syndromes has had extremely positive effect, use of either one in the courtroom without a clear under-
standing of their empirical limitations is a potential pitfall for a clinician. On the positive side, as was stated, RTS served as a springboard for more controlled studies on rape and its psychological impact. In addition, empirical studies in the 1980s and 1990s confirmed many of the victim responses characterized in RTS, including depression, anxiety, fear, and interpersonal problems (Ellis, 1983; Resick, 1993). Nonetheless, the existence of the model itself has not been replicated in studies, and many courts have excluded testimony regarding the syndrome on the grounds that it was prejudicial to the defense of the alleged offender and could be interpreted as an expert opinion as to whether the woman was or was not raped (Koss et al., 1994).

Empirical studies have generally supported the sequelae described in the BWS (especially that of PTSD). In addition, Walker’s pioneering work with BWS pushed the courts to acknowledge the influence of domestic violence on a woman and that the experience of abuse is reasonably considered an evidentiary matter in a legal case. Use of expert witness testimony using BWS also helped expand the understood meaning of self-defense beyond the narrow immediacy of fighting off a physical attack to incorporate circumstances in which the woman struck back at the offender when he appeared to be unexpectant of her aggression. Psychologically, the court was incorporating how a woman’s affirmative actions were based on her appraisal of a situation as dangerous, not through the traditional legal construct of immediacy. Some have argued, however, that the process by which these positive effects in the courts were achieved on behalf of battered women carried with it a high price: that being application of a psychological construct built on the notion that a woman who acts out violently against the offender is operating under circumstances of diminished capacity (Stark, 1992). Several authors have pointed out that BWS was not intended as a diminished capacity defense, but that in application, this is the effect (Dutton, 1994). Evaluating the clinical usefulness of these syndromes should include consideration of three questions: 1) do the symptoms associated with that syndrome represent the primary psychological responses to that type of violence; 2) it is valid to view a post-assault syndrome as a single, unitary phenomenon; and 3) does the presence of an assault syndrome mean definitively that the assault took place) (Briere, 2004; Briere & Jordan, in press). RTS and BWS fare moderately well to the first question in that most of the psychological
reactions they describe have also been documented in other research. The syndromes fare less well when considering the question of a unitary phenomenon in that the type of reaction by a given victim to an assault experience will vary significantly based on a number of other internal and external factors (e.g., prior abuse, co-existing mental health problems, severity of the current assault, existence of support following the assault), it is not solely based on the assault experience. Third, the syndromes fail on the final question in that “there is very little reason to believe that the presence or absence of RTS or BWS is diagnostic of assault exposure” (Briere & Jordan, in press). In a similar critique, it has been pointed out that there is no unified set of criteria by which to reliably determine whether the syndrome applies in a given case (Dutton, in press).

The most important guidance for clinicians to avoid the pitfalls associated with use of these syndromes in court cases is to remain mindful of their empirical limitations and avoid rendering an expert opinion regarding whether a woman has or has not been victimized based on the presence or absence of a specific cluster of psychological symptoms. Alternatively, clinical forensic hypothesis testing, which involves examining each issue in a woman’s case based on its own theoretically-driven formulation and clinical assessment has been suggested (Dutton, in press). For example, as Dutton points out, “... a battered woman’s appraisal or perception of deadly threat requires the identification of coherent pathways that are generally supported theoretically and empirically in the scientific literature and that are amenable to forensic evaluation” (Dutton, in press).

CAUTIONS ABOUT INDIVIDUAL PSYCHOTHERAPY WITH INTIMATE PARTNER VIOLENCE OFFENDERS

Group intervention has been described as the most appropriate treatment modality for intimate partner violence offenders, in part, because it expands the social networks of offenders to include men who support nonviolence (Crowell & Burgess, 1996). In individual therapy, it is difficult for therapists to remain as topic focused as is recommended in most batterer intervention programs, especially those that are based on cognitive behavioral or social learning approaches (Tolman & Bennett, 1990). Regardless of their theoretical perspectives, most clinicians tend to follow the client’s lead in sessions, and the operating premises of most psychotherapies call for
a client-centered or client-empowering approach. Offenders in individual therapy are remarkably adroit at shifting attention away from their behavior and on to other targets; consequently the clinician must be steadfast in insisting that the focus of therapy remains on the offender’s behavior, a requirement that can tax even the most diligent of therapists. Another advantage of a group format is that it facilitates peer confrontation and peer support—two very helpful tools in working with offenders. Clients who are making progress tend to exert positive influences on those who lag behind, and they can confront each other in ways that clinicians cannot. Groups can also be topical from session to session, and one can be assured that every client has been presented with the content planned by the clinician. Finally, supportive individual therapy can too easily become a method by which the offender rationalizes his conduct if a supportive clinician unwittingly endorses violence. Unless the clinician can constantly confront the offender’s thinking and rationalizations for violent behavior, individual therapy may serve to indulge the offender’s traditional defenses and excuses for his conduct and should be considered a pitfall to avoid.

CAUTIONS ABOUT MARITAL OR COUPLE THERAPY

A significant number of couples seeking help for their relationship present with some evidence of intimate partner violence. In fact, in one study, 50%–70% of couples presenting for treatment at clinics reported aggression in their relationships (Cascardi, Langhinrichsen, & Vivian, 1992). The decision regarding the appropriateness of conjoint therapy should be left to the clinician following a screening for intimate partner violence—it should not be a determination based solely on the request of the clients, nor on a referral from the court. In fact, there is fairly widespread agreement that couple therapies are not appropriate with court mandated or severely violent men (see Crowell & Burgess, 1996, p. 134). As noted by one author, “Couples counseling may be suitable for some couples on a voluntary basis and after careful screening for threats and coercion, but it does not appear to be particularly practical or suitable for most court-referred cases” (Gondolf, 2002, p. 15). Clinicians must keep in mind when making a determination regarding the appropriateness of conjoint therapy that both victims and offenders tend to
minimize the violence or the severity of its impact. A complete assessment and full disclosure of violence is unlikely when a victim is seated next to a violent intimate partner. This alone suggests a general rule of thumb that conjoint therapy for intimate partner violence cases is contraindicated.

The recommended approach following assessment of mild and noncontinuing violence is to proceed with couples counseling but to continuously reassess for violence or its precursors and to adjust the treatment approach accordingly so as to not prescribe increased conflict as a means of seeking relationship resolution. Likewise, adopting a position of strengthening the relationship can be a major problem if there is violence in the relationship. Caution, continually reassessed risk and openness to changing strategies is important in providing safe couples counseling. Conflicts between feminist and traditional systemic or behavioral approaches with couples have not been resolved, though some have proposed limited use of traditional approaches once the level of violence has been found to be mild and nonrecurring (Gauthier & Levendosky, 1996).

In summary, research on the safety effectiveness of couples counseling has not been conducted with sufficient controls to warrant recommended use of conjoint counseling in violent relationships (Aldarondo & Mederos, 2002). Some who propose using conjoint approaches for couples with violence accept some level of recurring violence during and after treatment (Brown & O’Leary, 1997) an idea that has little endorsement in the domestic violence field.

CAUTIONS ABOUT ALCOHOL AND DRUG ABUSE COUNSELING

As has been discussed, alcohol and drug abuse frequently co-occur with intimate partner violence. This coexistence is particularly important clinically because concurrent alcohol/drug abuse often increases the severity of intimate partner violence, and victimization in turn is related to increased substance use. Treatment models that address only one of the two problems are not only ineffective, they may risk safety for a victim and sobriety for a substance user. Alcohol and drug counselors are cautioned not to assume that a cessation of alcohol or drug use by an offender will also ensure nonviolence, as that belief is a pitfall that will lead to ineffective and risky treatment.
CAUTIONS ABOUT PASTORAL OR CHRISTIAN COUNSELING

Support and counseling from a clinician identified as a pastoral or a Christian counselor can have an extremely positive effect for a victim, as the church is a traditional and very powerful support system for many women. In addition, Christian-focused counseling can address the spiritual aspects of the victim’s experience if that is of relevance or significance to her life. There is potential risk with this approach, however. If it maintains a strict adherence, without regard for the victim’s safety, to the traditional Christian emphasis on valuing the marital bond, pastoral counseling may limit a victim’s ability to access necessary forms of protection for herself and her children. A related problem is encountered when a pastoral counselor focuses almost exclusively on the behavior of a victim as a means to control or prevent the violence of an offender (e.g., exhorting her to be a more supportive wife or to pray for nonviolence). If a pastoral or Christian counselor avoids these types of pitfalls, the intervention can be of assistance, particularly for victims who already feel established trust with their pastoral or Christian counselor and feel safe to fully disclose their victimization. For victims who desire spiritual guidance as they deal with the trauma of the abuse, pastoral counseling can be an especially comforting form of treatment.

THE IMPACT OF HELPING: SECONDARY TRAUMATIZATION

The study of traumatic stress has evolved over the past two decades, expanding to encompass the field’s growing understanding of the multiple victims who are impacted by a single trauma. A significant event in this progress was the 1980 publication of DSM-III, that included the diagnostic category of posttraumatic stress disorder (American Psychiatric Association, 1980). For the first time, a formal conceptualization existed for the common symptoms experienced by those who had faced trauma. The early focus of the trauma literature was limited to the primary victim of the incident, but over time understanding of the breadth of trauma’s impact expanded to include not only those who directly experience or witness traumagenic events but also those indirectly exposed to them and their
“The professional work centered on the relief of the emotional suffering of clients automatically includes absorbing information that is about suffering. Often it includes absorbing that suffering itself as well.” (Figley, 1995, p. 2)

consequences. The DSM-IV includes, within what constitutes a sufficiently traumatic experience, the following language:

“The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1).” [Italics added.] (APA, 1994, p. 424).

Clinicians who provide services to intimate partner violence victims and who are routinely exposed to the trauma stories of their clients may be included in the latter part of the criterion description. Historically, the physical, emotional, and behavioral sequelae associated with providing human services has been described as “burnout,” an occupational side-effect characterized by a chronic, progressive condition involving depersonalization, a reduced sense of personal accomplishment, and discouragement (Cherniss, 1980; Courage & Williams, 1986; Freudenberger, 1986; Kahill, 1988; Maslach, 1982; Maslach & Jackson, 1981). Burnout is a process of demoralization involving the deterioration and depletion clinicians experience from excessive work-related demands (Freudenberger, 1984), especially when working with a broad range of client populations. In recent years, however, research has focused more narrowly on the unique impact of working with clients whose stories of trauma expose clinicians to acute images of suffering, leading to development of the terms “secondary victimization” (Figley, 1993), “vicarious traumatization,” (McCann & Pearlman, 1990), and “emotional contagion” (Miller, Stiff, & Ellis, 1988). More recently, Figley has suggested the term “compassion fatigue” to describe the by-product of trauma-related mental health work (Figley, 1995).
These terms may be more useful to professionals in the trauma field than the term burnout, as they highlight the unique characteristics of trauma work and because they incorporate in their conceptualizations the more sudden onset of symptoms that is common for trauma clinicians (Figley, 1995). In addition, terms such as compassion fatigue or secondary trauma focus attention on the characteristics of the work that elicit symptoms from clinicians rather than focusing on what may be perceived as weaknesses or shortcomings of clinicians themselves.

Some authors argue that secondary or vicarious traumatization is an unavoidable result of trauma counseling and observe that the nightmares, fearful thoughts, and intrusive images suffered by clinicians are very similar to the symptoms experienced by trauma victims (McCann & Pearlman, 1990). Surveys with female psychologists and counselors for sexual violence victims, for example, have found that clinicians with a higher percentage of victims of sexual violence in their caseloads experience more symptoms of posttraumatic stress (Schauben & Frazier, 1995). In one study of licensed psychologists, researchers found that working with victims of sexual violence was positively correlated with emotional exhaustion and depersonalization, a finding particularly true of younger practitioners in the study (Ackerley et al., 1988). Several researchers have identified post-trauma related symptoms in clinicians providing services to victims. For example, a study of counselors working with sexual abuse survivors found that the current percentage of victims in their client caseloads, the percentage and career total of direct service hours with those clients, and the level of exposure to graphic details regarding the sexual abuse of their clients contributed significantly to the post-trauma symptoms experienced by the clinical staff (Brady, Guy, Poelstra, & Brokaw, 1999).

Finally, a recent study of female and male counselors explored the impact of hearing traumatic material; the way in which the counselors were changed as a result; and the way they coped with the challenges of their work (Iliffe & Steed, 2000). All the counselors in the study identified a loss in confidence in their own skill and a tendency to take too much responsibility for the welfare of their clients. Both female and male counselors struggled with maintaining respect for their clients’ choices, particularly those involved in a victim’s return to a violent home. Counselors in the study also felt they could no longer be shocked after hearing stories of horror from
their clients, and most experienced visual images of what they were
told. Physical responses were reported by a number of clinicians,
including a general feeling of heaviness, nausea, and feeling shaken
or exhausted. Changes to cognitive schema such as feeling less
secure in the world, changes to their worldview, regarding others
more warily, and experiencing an increased awareness of gender
power and control issues were common among intimate partner
violence counselors.

Working with offenders also impacts clinicians, with some re-
porting that engaging abusive men in treatment is the most challeng-
ing aspect of their work (Iliffe & Steed, 2000). Almost a third of
clinicians working with offenders report experiencing increases in
emotional, psychological, and physical symptoms (Edmunds, 1997)
and over half report becoming discouraged about client change,
lowering expectations when working with sex offenders, and experi-
encing emotional hardening, increased anger, decreased tolerance,
and an increase in confrontational behavior (Farrenkopf, 1992). Fi-
ally, clinicians working with threatening clients report becoming
more cautious in personal relationships and more concerned about
family safety (Ellerby, 1997). They also feel more anxious about their
children’s safety and are more vigilant around strangers (Jackson,
Holzman, & Barnard, 1997).

**CONTEXTUAL FACTORS: WHAT THE WORK BRINGS TO THE CLINICIAN**

While work with trauma survivors and victims of crime can be ex-
traordinarily rewarding, its unique demands, stresses, and responsi-
bleilities can challenge the most seasoned clinician. A clinician may
be the first person outside a victim’s family to hear about physical
or sexual abuse in a home. A clinician may be asked to explain the
“why” of unexpected trauma and destruction of life associated with
violent death. Clinicians hear the anguish of children and adults who
are victims or who are grieving over the loss of a loved one. They
may also be exposed to vivid, graphic stories of horror and physical
injury sustained by clients. Clinicians hear cold recounts by offend-
ers of deliberately inflicting pain on another person and may be
targets of the anger of a victim who cannot safely display her grief
and rage in another setting. Finally, clinicians working with victims
and offenders may be called upon by a court or protection agency to conduct an evaluation regarding the safety of a victim or the danger posed by an offender, recommendations that can have life-altering implications. These experiences highlight both the challenges and the rewards of therapeutic work in this area.

In the intimate partner violence arena, it is also important to consider the danger that offenders can pose to clinicians themselves. Clinicians, whether treating the victim or the offender, should be especially cautious of this risk when offering services at the point a victim leaves the offender, as the point of separation in a relationship has been associated with increased risk for a victim and may also elevate risk for others in the victim’s environment. Offenders may be threatened by the work a clinician is doing with a victim, particularly if he perceives her therapy as a threat to the continuation of his relationship. A clinician may also be blamed by an offender for what he perceives to be an intrusion into his relationship and damage to his ability to control his partner. Treating or evaluating clinicians testifying in court on behalf of a victim may also be exposed to retaliation from an offender, either in advance of the testimony as a means to influence the clinician’s testimony, or after the trial as a means of seeking retribution. Finally, clinicians treating offenders may also incur the anger of an offender as a result of the confrontation that is typically a part of the treatment regimen with intimate partner offenders or when they report back to a court incidents of noncompliance by the offender.

Research has documented the frustration that victims often feel when they seek the court’s protection or prosecute an offender. A victim’s encounter with the court system can also leave clinicians feeling frustrated by the institutional barriers within the justice system that contravene therapeutic goals and seem unjust to victim-clients. Examples of these frustrations include: seeing a victim’s pleas to law enforcement for the arrest of a repetitively abusive partner go unheeded; seeing a victim’s request for civil protection rejected; seeing a violent offender successfully win visitation rights to the victim’s children; or seeing an offender win acquittal when the clinician believes that he should have been convicted of a crime.

Finally, clinicians may feel very ambivalent about the uncertain success of intervention with a client when she chooses to return to a home with ongoing risk and violence.
“By virtue of having ‘been there,’ the clinician who has worked through and come to terms with his or her own abuse history may be optimally suited to provide sensitive, nondiscounting services to other survivors. In fact, the survivor-clinician may be able to understand the survivor-client’s experience and responses in ways that the clinician with no such history rarely can. It is probably true, in this regard, that some of the very best abuse-focused psychotherapists are survivors who have addressed and integrated their own early histories.” (Briere, 1992, p. 159)

**ABUSE HISTORIES: WHAT THE CLINICIAN BRINGS TO THE WORK**

A history of abuse in childhood is not uncommon among clinicians (Elliott & Guy, 1993; Follette, Polusny, & Milbeck, 1994; Pope, Feldman-Summers, 1992). In a study of male and female clinicians, 17% of the clinicians (13% of male clinicians and 20% of female clinicians) reported a personal history of childhood sexual abuse; and 7.3% of males and 6.9% of females reported physical abuse histories (Nuttall & Jackson, 1994). Including both sexual and physical abuse histories, the percentage increased to 21% of clinicians. Other studies report even higher rates, with 29.8% of clinicians (36% of female clinicians and 23% of male clinicians) experiencing some form of childhood trauma in one study (Follette, Polusny, & Milbeck, 1994) and in another, 33.1% of mental health professionals reporting a history of sexual or physical abuse during childhood (Pope & Feldman-Summers, 1992). In the latter study, 36.6% of study participants reported experiencing some form of abuse during adulthood (Pope & Feldman-Summers, 1992).

Abuse histories may change the way a clinician responds to or is impacted by clinical work. For example, in one study, clinicians who had been sexually abused and/or physically abused were more likely to believe allegations of sexual abuse contained in 16 vignettes alleging sexual abuse (Nuttall & Jackson, 1994). Other writers have documented that trauma clinicians with personal trauma histories showed more negative effects from their professional work than those without a personal history (Pearlman & McMan, 1995). Clinicians with abuse histories may be at risk for two types of boundary violations: overidentifying with the client’s experience through acutely empathetic responses and over disclosure, or a defense-
driven underidentification with a client (Wilson & Lindy, 1994; Marvasti, 1992). Similarly, Briere (1992) points out three areas of risk for survivor-clinicians:

**Overidentification** occurs when the clinician reacts in an unconsciously intensified way to those aspects of the client’s experience that most resemble that of the clinician. Clinicians who have not resolved their own abuse experiences may be at risk for overreacting to a client’s disclosure of an event or type of abuse experience that reminds the clinician of her or his own history. At an affective level, that may include feeling intense sadness or anger; at a behavioral level it may include directing the client to take certain actions (i.e., to prosecute or confront an offender), or it may be manifested in the clinician’s overinvestment in trying to comfort the client. In short, overidentification is evident when the clinician’s history of abuse contributes or alters the process of therapy with the client.

**Projection** occurs when the clinician confuses his or her own abuse issues with those of the client. Clinicians who have not resolved their own trauma history may also be at risk of projecting their own experience or reaction to abuse onto that of the client. For example, a clinician may perceive a client as more angry than she is; may interpret the lack of an overt response to abuse experiences as resolution by the client; or may believe the client to be resistant to change when in fact the client is afraid to take certain steps based on a realistic appraisal of the threat posed by an offender.

**Boundary confusion** occurs when the clinician’s abuse history encumbers his or her ability to discern appropriate interpersonal boundaries, particularly those of the therapeutic relationship. The most egregious boundary confusion (or violation) would be the circumstance of a sexual relationship between the clinician and the client. Boundary confusion in the intimate partner violence domain may be evidenced most commonly by clinicians who disclose details of their personal victimization during therapy with the client or by clinicians who ask overly intrusive questions.

**Mitigating the Effects of Secondary Trauma**

While clinical work in the intimate partner domain can be difficult work for clinicians, it is also replete with extremely positive and
rewarding aspects, such as the meaningfulness of being part of the healing process, the joy of seeing clients change and grow, and the satisfaction associated with contributing—not only at an individual clinical level, but in the broader sense of helping society as a whole (Schauben & Frazier, 1995).

There are numerous steps that clinicians and mental health agencies can take in order to mitigate the negative effects associated with this area of mental health practice. These can include avoiding the isolation that can occur inadvertently when only one clinician in an office serves victims and offenders, or when a clinician is the only therapist in an office (Jordan & Walker, 1994). It is also important to ensure that adequate training is available to all clinicians and clinical supervisors (Iliffe & Steed, 2000; Jordan & Walker, 1994), as anxiety may be mitigated when a clinician feels a greater level of competence about how to intervene in these cases. Effective training will also reduce the likelihood that a clinician will succumb to one of the pitfalls identified in this chapter and will therefore avoid the stress associated with making an error that is harmful to a client. Clinicians and their supervisors need to discuss whether it is advisable for the clinician’s caseload to be made up only of intimate partner violence clients or whether a more diverse caseload (i.e., including clients without current victimization) would help avoid some of the negative impacts of routinely hearing traumagenic material (Iliffe & Steed, 2000; Jordan & Walker, 1994). It is also recommended that trauma clinicians receive clinician supervision from a therapist with specific expertise in post-traumatic stress and trauma-related clinical work (Pearlman & Saakvitne, 1995); and that a regular time be set aside in staff meetings solely for the purpose of addressing feelings and concerns of clinical staff as a means of mediating or reducing the impact of vicarious trauma (Brady et al., 1999). Finally, debriefing sessions are recommended when a particularly difficult case is handled by a clinician or mental health agency. This may include cases of especially egregious abuse; cases in which a client dies; or cases that involve some type of harm to clinical staff. Care must be taken so as not to overwhelm clinicians with the constant presentation of traumatic material (Jordan & Walker, 1994; McCann & Pearlman, 1990).
Chapter 7 described the unique parameters of mental health practice in intimate partner violence cases. The broadening view of who the client is; the need to work in teams rather than in individual clinical practice; the management of clinical information in the court system; and the role of expert witnesses were explored. Chapter 7 also described common pitfalls encountered by clinicians in these cases and addressed the impact on clinicians of clinical work in this area. Readers should be able to answer the following questions following a review of chapter 7:

- What are the risks associated with the introduction of a victim’s mental health record in a court proceeding?
- Which of the “common pitfalls” do you believe are made by most mental health professionals? To which pitfall are you most susceptible?
- What are some of the challenging “contextual factors” of intimate partner violence work that can stress a clinician?
- What are the implications of having an abuse history for a clinician working with victims of intimate partner violence?
- What are three mitigators of secondary trauma?