



The ethics of IPV counseling: One provider's experience

The Centers for Disease Control and Prevention (CDC) defines intimate partner violence (IPV) as “violence or aggression that occurs in a close relationship.” This can include physical or sexual violence, stalking or psychological aggression. In a 2010 survey, more than 27% of women and 11% of men reported having experienced IPV, according to the CDC.

Given those numbers, it is likely that counselors will find themselves treating either victims or perpetrators of IPV. But what happens when victims and offenders seek treatment together in the context of couples or family counseling? Allison Kramer encountered this dilemma many times in her work as a provider of court-ordered IPV offender treatment in Colorado.

Kramer, a licensed professional counselor and a licensed addictions counselor, found that she was torn between following regulations and policies and providing the treatment that her clients needed. In this month's column, we will see how Kramer used the 2014 *ACA Code of Ethics* to take a deeper look at these dilemmas and come to a decision about how best to serve her clients. Although some of the regulations discussed in this article are state specific, the themes of handling mandated clients, addressing policies that may be in conflict with our ethical values as counselors, and working for the benefit and welfare of our clients are universal.

History of the Duluth Model

In the early 1980s, the Duluth Model of treatment was created in response to a history of law enforcement refusing to intervene in incidents of IPV. Sadly, this was following IPV-related murders that, arguably, could have been prevented.

Today, the Duluth Model is used in

many states. When police are called to an IPV scene and find probable cause for an arrest to be made, one or both partners will be arrested and removed from the situation. Following an arrest, the prosecution will typically press IPV-related charges against the perpetrator, regardless of whether the victim desires this. This idea is rooted in the psychoeducational and harm reduction model. If perpetrators plead guilty to an IPV-related offense, in lieu of jail time, they receive a suspended sentence requiring them to attend court-ordered treatment. This treatment is monitored through probationary requirements, including participating in mandatory weekly cognitive behavior group counseling with other offenders.

State regulations and mandated treatment

Based on the Duluth Model, many states, including Colorado, have codified IPV offender treatment. The first step in this process is training for clinicians who wish to provide IPV offender treatment, a prerequisite to being approved by the Domestic Violence Offender Management Board (DVOMB). This training includes teaching treatment providers how to administer tools such as the Domestic Violence Risk and Needs Assessment and the Substance Abuse Subtle Screening Inventory to assess offender risk for reoffense while in treatment.

On the basis of assessment results, client biopsychosocial history, legal history, and the victim impact statement, the evaluating provider recommends a treatment level (low, moderate or high). In the DVOMB system, there is no option to recommend another type of treatment outside of those three levels, even if the provider believes an alternative treatment path would be most beneficial.

An extra concern comes when couples who have experienced IPV wish to attend couples or family counseling. Statistically, the majority of offenders and victims will reunite after an IPV arrest for a multitude of reasons. Interestingly, in Colorado and in many other states that follow the Duluth Model, couples counseling or joint counseling of any kind is legally prohibited in cases of IPV, according to DVOMB standards.

Standard A.2.e. of the 2014 *ACA Code of Ethics* makes clear counselors' responsibilities to mandated clients. In addition to providing the information that counselors give to all clients through the informed consent process, counselors of clients who have been mandated need to be clear that confidentiality will be more limited. In mandated treatment, counselors are often required to report to authorities about clients' treatment progress and sometimes must report any prohibited behaviors that might violate the clients' probation. This can vary widely based on the type and location of treatment, so counselors should always be clear with clients about what type of information counselors are required to share and with whom they must share it. It is important to let clients know that they can refuse treatment under these terms but that there may be a consequence for doing so.

Therefore, Kramer had to make it clear from the outset that the type of services she was providing to court-ordered IPV offenders was not dictated by her but, rather, by Colorado law. Furthermore, the philosophy of treatment required was one of containment, and it was heavily controlled by the criminal justice system. According to her training and the program requirements, Kramer also had to express support for the Duluth Model

of treatment. As time went on, however, Kramer found that her clinical judgment conflicted with the model and her state's law. This presented her with a dilemma of how to be authentic and act in the best interests of her clients while still working within this constraining framework.

Resolving incongruences in ethics and practice

The 2014 *ACA Code of Ethics* calls for counselors to be respectful of approaches other than their own, so long as these approaches are theoretically or empirically sound and not harmful to clients. However, the ethics code also stresses that counselors should operate with veracity and deal truthfully with clients. Therefore, it is not surprising that Kramer felt her lack of faith in the IPV treatment system containment model was doing her clients a disservice. She may have respected others who used this model, but having to implement it herself when she felt it did not meet her clients' needs felt inauthentic. Nevertheless, she continued to provide court-ordered treatment for two more years. At one point, these clients constituted about 50% of her private practice caseload, and she found her financial stability contingent on providing these services. Because of her incongruence with the Duluth Model and the state's regulations, however, this proved to be unsustainable.

The *ACA Code of Ethics* encourages counselors, in Standard D.1.h., to notify employers of policies and procedures that might be harmful to clients or that are in conflict with counselors' professional values and ethics. Of course, this is something that is often easier said than done. It can be hard to effect change even when dealing with a small practice, let alone in a large organization or, in Kramer's case, with state laws.

If counselors find that they cannot effect change "through constructive action within the organization," as advised in Standard D.1.h., they can take "appropriate further action [which may] include referral to appropriate certification, accreditation or state licensure organizations, or voluntary termination of employment." These are hard choices that each counselor must make for himself or herself. However, if thoughts such as "it will all work out" or rationalizations

such as "I need the money" or "nothing's perfect" continue to crop up, that should be a sign for counselors to examine closely what is really happening.

Ultimately, Kramer chose the latter option. She stopped providing court-ordered IPV offender treatment services, even though she was good at this work and sometimes even enjoyed it. She felt that she had to make this decision because she knew she was violating her professional ethics code and her own values.

Conclusion

It is likely that many counselors have had similar experiences, whether it involved disagreeing with the policies of the community counseling agencies in which they worked, questioning the qualifications and expertise of colleagues or supervisors, or encountering some other situation that caused them to question their "fit" within the counseling field or their place of employment. In their book *Ethics for Psychotherapists and Counselors: A Proactive Approach*, Sharon Anderson and Mitchell Handelsman label these mismatches as crises of "ethical acculturation."

When counselors experience such mismatches, they should take steps to resolve them. To ignore them, soldier on and deny the impact on clients' well-being — and their own — is harmful, professionally and personally. Ultimately, it is unethical. ❖

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