



# Department of Defense MANUAL

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USD(P&R)

SUBJECT: Family Advocacy Program (FAP): Guidelines for Clinical Intervention for Persons Reported as Domestic Abusers

References: See Enclosure 1

## 1. PURPOSE

a. Manual. This manual is composed of several volumes, each containing its own purpose. The purpose of the overall manual, in accordance with the authority in DoD Directive 5124.02 (Reference (a)) and DoD Instruction (DoDI) 6400.01 (Reference (b)), is to implement policy, assign responsibilities, and provide procedures for addressing child abuse and domestic abuse in military communities.

b. Volume. Restricted reporting guidelines are provided in DoDI 6400.06 (Reference (c)). This volume prescribes guidelines for FAP assessment, clinical rehabilitative treatment, and ongoing monitoring of individuals who have been reported to FAP by means of an unrestricted report for domestic abuse against:

- (1) Current or former spouses, or
- (2) Intimate partners.

2. APPLICABILITY. This volume applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to in this volume as the "DoD Components").

3. POLICY. In accordance with References (b) and (c), it is DoD policy to:

a. Develop program standards and critical procedures for the FAP that reflect a coordinated community response to domestic abuse.

b. Address domestic abuse within the military community through a coordinated community risk management approach.

c. Provide appropriate individualized and rehabilitative treatment that supplements administrative or disciplinary action, as appropriate, to persons reported to FAP as domestic abusers.

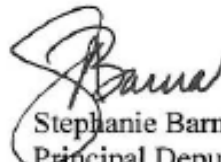
4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. Enclosure 3 provides procedures for clinical intervention for persons reported as domestic abusers.

6. RELEASABILITY. **Cleared for public release**. This volume is available on the DoD Issuances Website at <http://www.dtic.mil/whs/directives>.

7. SUMMARY OF CHANGE 1. The changes to this issuance are administrative and update URLs and references for accuracy.

8. EFFECTIVE DATE. This volume is effective March 2, 2015.



Stephanie Barna  
Principal Deputy Assistant Secretary of Defense  
Performing the Duties of the Assistant  
Secretary of Defense (Readiness and Force  
Management)

Enclosures

1. References
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Glossary

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ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5124.02, “Under Secretary of Defense for Personnel and Readiness (USD(P&R)),” June 23, 2008
- (b) DoD Instruction 6400.01, “Family Advocacy Program (FAP),” February 13, 2015
- (c) DoD Instruction 6400.06, “Domestic Abuse Involving DoD Military and Certain Affiliated Personnel,” August 21, 2007, as amended
- (d) Chapter 47 of Title 10, United States Code (also known as “The Uniform Code of Military Justice (UCMJ)”)
- (e) DoD 5400.11-R, “Department of Defense Privacy Program,” May 14, 2007
- (f) DoD 6025.18-R, “DoD Health Information Privacy Regulation,” January 24, 2003
- (g) Title 42, United States Code
- (h) DoD Manual 6400.01, Volume 2, “Family Advocacy Program (FAP): Child Abuse and Domestic Abuse Incident Reporting System,” August 11, 2016

ENCLOSURE 2

RESPONSIBILITIES

1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R):

a. Sponsors FAP research and evaluation and participates in other federal research and evaluation projects relevant to the assessment, treatment, and risk management of domestic abuse.

b. Ensures that research is reviewed every 3 to 5 years and that relevant progress and findings are distributed to the Secretaries of the Military Departments using all available Web-based applications.

c. Assists the Secretaries of the Military Departments to:

(1) Identify tools to assess risk of recurrence.

(2) Develop and use pre- and post-treatment measures of effectiveness.

(3) Promote training in the assessment, treatment, and risk management of domestic abuse.

2. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments issue implementing guidance in accordance with References (b) and this manual. The guidance must provide for the clinical assessment, rehabilitative treatment, and ongoing monitoring and risk management of Service members and eligible beneficiaries reported to FAP for domestic abuse by means of an unrestricted report.

ENCLOSURE 3

PROCEDURES

1. GENERAL PRINCIPLES FOR CLINICAL INTERVENTION

a. Components of Clinical Intervention. The change from abusive to appropriate behavior in domestic relationships is a process that requires clinical intervention, which includes ongoing coordinated community risk management, assessment, and treatment.

b. Military Administrative and Disciplinary Actions and Clinical Intervention. The military disciplinary system and FAP clinical intervention are separate processes. Commanders may proceed with administrative or disciplinary actions at any time.

c. Goals of Clinical Intervention. The primary goals of clinical intervention in domestic abuse are to ensure the safety of the victim and community, and promote stopping abusive behaviors.

d. Therapeutic Alliance

(1) Although clinical intervention must address abuser accountability, clinical assessment and treatment approaches should be oriented to building a therapeutic alliance with the abuser so that he or she is sincerely motivated to take responsibility for his or her actions, improve relationship skills, and end the abusive behavior.

(2) Clinical intervention will neither be confrontational nor intentionally or unintentionally rely on the use of shame to address the abuser's behavior. Such approaches have been correlated in research studies with the abuser's premature termination of or minimal compliance with treatment.

(a) It is appropriate to encourage abusers to take responsibility for their use of violence; however, in the absence of a strong, supportive, therapeutic relationship, confrontational approaches may induce shame and are likely to reduce treatment success and foster dropout. Approaches that create and maintain a therapeutic alliance are more likely to motivate abusers to seek to change their behaviors, add to their relationship skills, and take responsibility for their actions. Studies indicate that a strong therapeutic alliance is related to decreased psychological and physical aggression.

(b) A clinical style that helps the abuser identify positive motivations to change his or her behavior is effective in strengthening the therapeutic alliance while encouraging the abuser to evaluate his or her own behavior. Together, the therapist and abuser attempt to identify the positive consequences of change, identify motivation for change, determine the obstacles that lie in the path of change, and identify specific behaviors that the abuser can adopt.

e. Criteria for Clinical Intervention Approaches. Clinical intervention approaches should reflect the current state of knowledge. This volume recommends an approach (or multiple approaches) and procedures that have one or more of these characteristics:

- (1) Demonstrated superiority in formal evaluations in comparison to one or more other approaches.
- (2) Demonstrated statistically significant success in formal evaluations, but not yet supported by a consensus of experts.
- (3) The support of a consensus due to significant potential in the absence of statistically significant success.
- (4) Significant potential when consensus does not yet exist.

f. Clinical Intervention for Female Abusers. Findings from research and clinical experience indicate that women who are domestic abusers may require clinical intervention approaches other than those designed specifically for male abusers.

- (1) Attention should be given to the motivation and context for their use of abusive behaviors to discover whether or not using violence against their spouse, former spouse, or intimate partner has been in response to his or her domestic abuse.
- (2) Although both men and women who are domestic abusers may have undergone previous traumatic experiences that may warrant treatment, women's traumatic experiences may require additional attention within the context of domestic abuse.

g. Professional Standards. Domestic abusers who undergo clinical intervention will be treated with respect, fairness, and in accordance with professional ethics. All applicable rights of abusers will be observed, including compliance with the rights and warnings in section 831, chapter 47 of Title 10, United States Code, also known and referred to in this volume as the "Uniform Code of Military Justice (UCMJ)" (Reference (d)), for abusers who are Service members.

- (1) Clinical service providers who conduct clinical assessments of or provide clinical treatment to abusers will adhere to Service policies with respect to the advisement of rights pursuant to the UCMJ, will seek guidance from the supporting legal office when a question of applicability arises, and will notify the relevant military law enforcement investigative agency if advisement of rights has occurred.
- (2) Clinical service providers and military and civilian victim advocates must follow the Privacy Act of 1974, and other applicable laws, regulations, and policies regarding the disclosure of information about victims and abusers.
- (3) Individuals and agencies providing clinical intervention to persons reported as domestic abusers will not discriminate based on race, color, religion, gender, disability, national



origin, age, or socioeconomic status. All members of clinical intervention teams will treat abusers with dignity and respect regardless of the nature of their conduct or the crimes they may have committed. Cultural differences in attitudes will be recognized, respected, and addressed in the clinical assessment process.

h. Clinical Case Management. The FAP clinical service provider has the responsibility for clinical case management.

## 2. COORDINATED COMMUNITY RISK MANAGEMENT

a. General. A coordinated community response to domestic abuse is the preferred method to enhance victim safety, reduce risk, and ensure abuser accountability. In a coordinated community response, the training, policies, and operations of all civilian and military human service and FAP clinical service providers are linked closely with one another. Since no particular response to a report of domestic abuse can ensure that a further incident will not occur, selection of the most appropriate response will be considered one of coordinated community risk management.

b. Responsibility for Coordinated Community Risk Management. Overall responsibility for managing the risk of further domestic abuse, including developing and implementing an intervention plan when significant risk of lethality or serious injury is present, lies with:

(1) The Service member's commander when a Service member is a domestic abuser or is the victim (or their military dependent is the victim) of domestic abuse.

(2) The commander of the installation or garrison on which a Service member who is a domestic abuser or who is the victim (or their military dependent who is the victim) of domestic abuse may live.

(3) The commander of the military installation on which the civilian is housed for a civilian abuser accompanying U.S. military forces outside the United States.

(4) The FAP clinical service provider or case manager for liaison with civilian authorities in the event the abuser is a civilian.

c. Implementation. Coordinated community risk management requires:

(1) The commander of the military installation to participate in local coalitions and task forces to enhance communication and strengthen program development among activities. In the military community, this may include inviting State, local, and tribal government representatives to participate in their official capacity as non-voting guests in meetings of the Family Advocacy Committee (FAC) to discuss coordinated community risk management in domestic abuse incidents that cross jurisdictions. (See volume 1 of this manual for FAC standards.)

(a) Agreements with non-federal activities will be reflected in signed memorandums of understanding (MOU).

(b) Agreements may be among military installations of different Military Services and local government activities.

(2) Advance planning through the installation FAC by:

- (a) The commander of the installation.
- (b) FAP and civilian clinical service providers.
- (c) Victim advocates in the military and civilian communities.
- (d) Military chaplains.
- (e) Military and civilian law enforcement agencies.
- (f) Military supporting legal office and civilian prosecutors.
- (g) Military and civilian mental health and substance abuse treatment agencies.
- (h) DoDEA school principals or their designees.
- (i) Other civilian community agencies and personnel including:
  - 1. Criminal and family court judges.
  - 2. Court probation officials.
  - 3. Child protective services agencies.
  - 4. Domestic abuse shelters.

(3) FAP clinical service providers to address:

(a) Whether treatment approaches under consideration are based on individualized assessments and directly address other relevant risk factors.

(b) Whether the operational tempo of frequent and lengthy deployments to accomplish a military mission affects the ability of active duty Service members to complete a State-mandated treatment program.

(c) Respective responsibilities for monitoring abusers' behavior on an ongoing basis, developing procedures for disclosure of relevant information to appropriate authorities, and implementing a plan for intervention to address the safety of the victim and community.

d. Deployment. Risk management of a Service member reported to FAP as a domestic abuser prior to a military deployment, when his or her deployment is not cancelled, or reported to FAP as a domestic abuser while deployed requires planning for his or her return to their home station.

(1) The installation FAC should give particular attention to special and early returns so during deployment of a unit, the forward command is aware of the procedures to notify the home station command of regularly-scheduled and any special or early returns of such personnel to reduce the risk of additional abuse.

(2) An active duty Service member reported as a domestic abuser may be returned from deployment early for military disciplinary or civilian legal procedures, for rest and recuperation (R&R), or, if clinical conditions warrant, for treatment not otherwise available at the deployed location and if the commander feels early return is necessary under the circumstances. To prevent placing a victim at higher risk, the deployed unit commander will notify the home station commander and the installation FAP in advance of the early return, unless operational security prevents such disclosure.

e. Clinical Case Management. Ongoing and active case management, including contact with the victim and liaison with the agencies in the coordinated community response, is necessary to ascertain the abuser's sincerity and changed behavior. Case management requires ongoing liaison and contact with multiple information sources involving both military and surrounding civilian community agencies. Clinical case management includes:

(1) Initial Clinical Case Management. Initial case management begins with the intake of the report of suspected domestic abuse, followed by the initial clinical assessment.

(2) Periodic Clinical Case Management. Periodic case management includes the FAP clinical service provider's assessment of treatment progress and the risk of recurrence of abuse. Treatment progress and the results of the latest risk assessment should be discussed whenever the case is reviewed at the clinical case staffing meeting (CCSM).

(3) Follow-Up. As a result of the risk assessment, if there is a risk of imminent danger to the victim or to another person, the FAP clinical service provider may need to notify:

(a) The victim or other person at risk and the victim advocate to review, and possibly revise, the safety plan.

(b) The appropriate military command, and military or civilian law enforcement agency.

(c) Other treatment providers to modify their intervention with the abuser. For example, the provider of substance abuse treatment may need to change the requirements for monitored urinalysis.

### 3. CLINICAL ASSESSMENT

a. Purposes. A structured clinical assessment of the abuser is a critical first step in clinical intervention. The purposes of clinical assessment are to:

(1) Gather information to evaluate and ensure the safety of all parties – victim, abuser, other family members, and community.

(2) Assess relevant risk factors, including the risk of lethality.

(3) Determine appropriate risk management strategies, including clinical treatment; monitoring, controlling, or supervising the abuser's behavior to protect the victim and any individuals who live in the household; and victim safety planning.

b. Initial Information Gathering. Initial information gathering and risk assessment begins when the unrestricted report of domestic abuse is received by FAP.

(1) Since the immediacy of the response is based on the imminence of risk, the victim must be contacted as soon as possible to evaluate her or his safety, safety plan, and immediate needs. If a domestic abuse victim advocate is available, the victim advocate must contact the victim. If a victim advocate is not available, the clinician must contact the victim. Every attempt must be made to contact the victim via telephone or e-mail to request a face-to-face interview. If the victim is unable or unwilling to meet face-to-face, the victim's safety, safety plan, and immediate needs will be evaluated by telephone.

(2) The clinician must interview the victim and abuser separately to maximize the victim's safety. Both victim and abuser must be assessed for the risk factors in paragraphs 3d and 3f of this enclosure.

(a) The clinician must inform the victim and abuser of the limits of confidentiality and the FAP process before obtaining information from them. Such information must be provided in writing as early as practical.

(b) The clinician must build a therapeutic alliance with the abuser using an interviewing style that assesses readiness for and motivates behavioral change. The clinician must be sensitive to cultural considerations and other barriers to the client's engagement in the process.

(3) The clinician must also gather information from a variety of other sources to identify additional risk factors, clarify the context of the use of any violence, and determine the level of risk. The assessment must include information about whether the Service member is scheduled to be deployed or has been deployed within the past year, and the dates of scheduled or past deployments. Such sources of information may include:

(a) The appropriate military command.

- (b) Military and civilian law enforcement.
- (c) Medical records.
- (d) Children and other family members residing in the home.
- (e) Others who may have witnessed the acts of domestic abuse.
- (f) The FAP central registry of child maltreatment and domestic abuse reports.

(4) The clinician will request disclosure of information and use the information disclosed in accordance with DoD 5400.11-R and DoD 6025.18-R (References (e) and (f)).

c. Violence Contextual Assessment. The clinical assessment of domestic abuse will include an assessment of the use of violence within the context of relevant situational factors to guide intervention. Relevant situational factors regarding the use of violence include, but are not limited to:

(1) Exacerbating Factors. Exacerbating factors include whether either victim or domestic abuser:

- (a) Uses violence as an inappropriate means of expressing frustrations with life circumstances.
- (b) Uses violence as a means to exert and maintain power and control over the other party.
- (c) Has inflicted injuries on the other party during the relationship, and the extent of such injuries.
- (d) Fears the other.

(2) Mitigating Factors. Mitigating factors include whether either victim or domestic abuser uses violence:

- (a) In self-defense.
- (b) To protect another person, such as a child.
- (c) In retaliation, as noted in the most recent incident or in the most serious incident.

d. Lethality Risk Assessment. The clinician must assess the risk for lethality in every assessment for domestic abuse, whether or not violence was used in the present incident. The lethality assessment will assess the presence of these factors:

- (1) For both victim and domestic abuser:
    - (a) Increased frequency and severity of violence in the relationship.
    - (b) Ease of access to weapons.
    - (c) Previous use of weapons or threats to use weapons.
    - (d) Threats to harm or kill the other party, oneself, or another (especially a child of either party).
    - (e) Excessive use of alcohol and use of illegal drugs.
    - (f) Jealousy, possessiveness, or obsession, including stalking.
  - (2) For the domestic abuser only:
    - (a) Previous acts or attempted acts of forced or coerced sex with the victim.
    - (b) Previous attempts to strangle the victim.
  - (3) For the victim only:
    - (a) The victim's attempts or statements of intent to leave the relationship.
    - (b) If the victim is a woman, whether the victim is pregnant and the abuser's attitude regarding the pregnancy.
    - (c) The victim's fear of harm from the abuser to himself or herself or any child of either party or other individual living in the household.
- e. Results of Lethality Risk Assessment. When one or more lethality factors are identified:
- (1) The clinician will promptly contact the appropriate commander and military or civilian law enforcement agency and the victim advocate.
  - (2) The commander or military law enforcement agency will take immediate steps to protect the victim, addressing the lethality factor(s) identified.
  - (3) The victim advocate will contact the victim to develop or amend any safety plan to address the lethality factor(s) identified.
  - (4) The commander will intensify ongoing coordinated community risk management and monitoring of the abuser.

f. Assessment of Other Risk Factors. The clinician will separately assess the victim and abuser for other factors that increase risk for future domestic abuse. Such risk factors to be assessed include, but are not limited to, the abuser's:

(1) Previous physical and sexual violence and emotional abuse committed in the current and previous relationships. The greater the frequency, duration, and severity of such violence, the greater the risk.

(2) Use of abuse to create and maintain power and control over others.

(3) Attitudes and beliefs directly or indirectly supporting domestic abusive behavior. The stronger the attitudes and beliefs, the greater the risk.

(4) Blaming of the victim for the abuser's acts. The stronger the attribution of blame to the victim, the greater the risk.

(5) Denial that his or her abusive acts were wrong and harmful, or minimization of their wrongfulness and harmfulness.

(6) Lack of motivation to change his or her behavior. The weaker the motivation, the greater the risk.

(7) Physical and/or emotional abuse of any children in the present or previous relationships. The greater the frequency, duration, and severity of such abuse, the greater the risk.

(8) Physical abuse of pets or other animals. The greater the frequency, duration, and severity of such abuse, the greater the risk.

(9) Particular caregiver stress, such as the management of a child or other family member with disabilities.

(10) Previous criminal behavior unrelated to domestic abuse. The greater the frequency, duration, and severity of such criminal behavior, the greater the risk.

(11) Previous violations of civil or criminal court orders. The greater the frequency of such violations, the greater the risk.

(12) Relationship problems, such as infidelity or significant ongoing conflict.

(13) Financial problems.

(14) Mental health issues or disorders, especially disorders of emotional attachment or depression and issues and disorders that have not been treated successfully.

(15) Experience of traumatic events during military service, including events that resulted in physical injuries.

(16) Any previous physical harm, including head or other physical injuries, sexual victimization, or emotional harm suffered in childhood and/or as a result of violent crime outside the relationship.

(17) Fear of relationship failure or of abandonment.

g. Periodic Risk Assessment. The FAP clinical service provider will periodically conduct a risk assessment with input from the victim, adding the results of such risk assessments to the abuser's treatment record in accordance with volume 1 of this manual, and incorporating them into the abuser's clinical treatment plan and contract. Risk assessment will be conducted:

(1) At least quarterly, but more frequently as required to monitor safety when the current situation is deemed high risk.

(2) Whenever the abuser is alleged to have committed a new incident of domestic abuse or an incident of child abuse.

(3) During significant transition periods in clinical case management, such as the change from assessment to treatment, changes between treatment modalities, and changes between substance abuse or mental health treatment and FAP treatment.

(4) After destabilizing events such as accusations of infidelity, separation or divorce, pregnancy, deployment, administrative or disciplinary action, job loss, financial issues, or health impairment.

(5) When any clinically relevant issues are uncovered, such as childhood trauma, domestic abuse in a prior relationship, or the emergence of mental health problems.

h. Assessment of Events Likely to Trigger the Onset of Future Abuse. The initial clinical assessment will include a discussion of potential events that may trigger the onset of future abuse, such as pregnancy, upcoming deployment, a unilateral termination of the relationship, or conflict over custody and visitation of children in the relationship.

i. Tools and Instruments for Assessment. The initial clinical assessment process will include the use of appropriate standardized tools and instruments, Service-specific tools, and clinical interviewing. Unless otherwise indicated, the results from one or more of these tools will not be the sole determinant(s) for excluding an individual from treatment. The tools should be used for:

(1) Screening for suitability for treatment.

(2) Tailoring treatment approaches, modalities, and content.

(3) Reporting changes in the level of risk.



(4) Developing risk management strategies.

(5) Making referrals to other clinical service providers for specialized intervention when appropriate.

#### 4. CLINICAL TREATMENT

a. Theoretical Approaches. Based on the results of the clinical assessment, the FAP clinical service provider will select a treatment approach that directly addresses the abuser's risk factors **and** his or her use of violence. Such approaches include, but are not limited to, cognitive and dialectical behavioral therapy, psychodynamic therapy, psycho-educational programs, attachment-based intervention, and combinations of these and other approaches. See paragraph 1e of this enclosure for criteria for clinical intervention approaches.

b. Treatment Planning. A FAP clinical service provider will develop a treatment plan for domestic abuse that is based on a structured assessment of the particular relationship and risk factors present.

(1) The treatment plan will not be based on a generic "one-size-fits-all" approach. The treatment plan will consider that people who commit domestic abuse do not compose a homogeneous group, and may include people:

(a) Of both sexes.

(b) With a range of personality characteristics.

(c) With mental illness and those with no notable mental health problems.

(d) Who abuse alcohol or other substances and/or use illegal drugs and those who do not.

(e) Who combine psychological abuse with coercive techniques, including violence, to maintain control of their spouse, former spouse, or intimate partner and those who do not attempt to exert coercive control.

(f) In relationships in which both victim and domestic abuser use violence (excluding self-defense).

(2) Due to the demographics of the military population, structure of military organizations, and military culture, it is often possible to intervene in a potentially abusive relationship before the individual uses coercive techniques to gain and maintain control of the other party. Thus, a reliance on addressing the abuser's repeated use of power and control tactics as the sole or primary focus of treatment is frequently inapplicable in the military community.

(3) Treatment objectives, when applicable, will seek to:

(a) Educate the abuser about what domestic abuse is and the common dynamics of domestic abuse in order for the abuser to learn to identify his or her own abusive behaviors.

(b) Identify the abuser's thoughts, emotions, and reactions that facilitate abusive behaviors.

(c) Educate the abuser on the potential for re-abusing, signs of abuse escalation and the normal tendency to regress toward previous unacceptable behaviors.

(d) Identify the abuser's deficits in social and relationship skills. Teach the abuser non-abusive, adaptive, and pro-social interpersonal skills and healthy sexual relationships, including the role of intimacy, love, forgiveness, development of healthy ego boundaries, and the appropriate role of jealousy.

(e) Increase the abuser's empathic skills to enhance his or her ability to understand the impact of violence on the victim and empathize with the victim.

(f) Increase the abuser's self-management techniques, including assertiveness, problem solving, stress management, and conflict resolution.

(g) Educate the abuser on the socio-cultural basis for violence.

(h) Identify and address issues of gender role socialization and the relationship of such issues to domestic abuse.

(i) Increase the abuser's understanding of the impact of emotional abuse and violence directed at children and violence that is directed to an adult but to which children in the family are exposed.

(j) Facilitate the abuser's acknowledgment of responsibility for abusive actions and consequences of actions. Although the abuser's history of victimization should be addressed in treatment, it should never take precedence over his or her responsibility to be accountable for his or her abusive and/or violent behavior, or be used as an excuse, rationalization, or distraction from being held so accountable.

(k) Identify and confront the abuser's issues of power and control and the use of power and control against victims.

(l) Educate the abuser on the impact of substance abuse and its correlation to violence and domestic abuse.

(4) These factors should inform treatment planning:

(a) Special Objectives for Female Abusers. Findings from research and clinical experience indicate that clinical treatment based solely on analyses of male power and control may not be applicable to female domestic abusers. Clinical approaches must give special attention to the motivation and context for use of violence and to self-identified previous traumatic experiences.

(b) Special Strategies for Grieving Abusers. When grief and loss issues have been identified in the clinical assessment or during treatment, the clinician will incorporate strategies for addressing grief and loss into the treatment plan. This is especially important if a victim has decided to end a relationship with a domestic abuser because of the abuse.

1. Abusers with significant attachment issues who are facing the end of a relationship with a victim are more likely to use lethal violence against the victim and children in the family. This is exemplified by the statement: “If I can’t have you no one else can have you.”

2. They are also more likely to attempt suicide. This is exemplified by the statement: “Life without you is not worth living.”

(c) Co-Occurrence of Substance Abuse. The coordinated community management of risk is made more difficult when the person committing domestic abuse also abuses alcohol or other substances. When the person committing domestic abuse also abuses alcohol or other substances:

1. Treatment for domestic abuse will be coordinated with the treatment for substance abuse and information shared between the treatment providers in accordance with applicable laws, regulations, and policies.

2. Special consideration will be given to integrating the two treatment programs or providing them at the same time.

3. Information about the abuser’s progress in the respective treatment programs will be shared between the treatment providers. Providing separate treatment approaches with no communication between the treatment providers complicates the community’s management of risk.

(d) Co-Occurrence of Child Abuse. When a domestic abuser has allegedly committed child abuse, the clinician will:

1. Notify the appropriate law enforcement agency and other civilian agencies as appropriate in accordance with section 13031 of Title 42, U.S.C. (Reference (g))

2. Notify the appropriate child protective services agency and the FAP supervisor to ascertain if a FAP child abuse case should be opened in accordance with Reference (c) and section 5106g of Reference (g).

3. Address the impact of such abuse of the child(ren) as a part of the domestic abuser clinical treatment.

4. Seek to improve the abuser's parenting skills if appropriate in conjunction with other skills.

5. Continuously assess the abuser as a parent or caretaker as appropriate throughout the treatment process.

6. Address the impact of the abuser's domestic abuse directed against the victim upon children in the home as a part of the domestic abuser clinical treatment.

(e) Occurrence of Sexual Abuse within the Context of Domestic Abuse. Although sexual abuse is a subset of domestic abuse, victims may not recognize that sexual abuse can occur in the context of a marital or intimate partner relationship. Clinicians should employ specific assessment strategies to identify the presence of sexual abuse within the context of domestic abuse.

(f) Deployment. Deployment of an active duty Service member who is a domestic abuser is a complicating factor for treatment delivery.

1. A Service member who is scheduled to deploy in the near future may be highly stressed and therefore at risk for using poor conflict management skills.

2. While on deployment, a Service member is unlikely to receive clinical treatment for the abuse due to mission requirements and unavailability of such treatment.

3. A deployed Service member reported to FAP as a domestic abuser may return from deployment early for military disciplinary or civilian legal procedures, for R&R, or if clinical conditions warrant early return from deployment for treatment not otherwise available at the deployed location and if the commander feels early return is necessary under the circumstances. The home station command and installation FAP must be notified in advance of the early return of a deployed Service member with an open FAP case, unless operational security prevents disclosure, so that the risk to the victim can be assessed and managed.

4. A Service member who is deployed in a combat operation or in an operation in which significant traumatic events occur may be at a higher risk of committing domestic abuse upon return.

5. The Service member may receive head injuries. Studies indicate that such an injury increases the risk of personality changes, including a lowered ability to tolerate frustration, poor impulse control, and an increased risk of using violence in situations of personal conflict. If the Service member has a history of a head injury prior to or during deployment, the clinician should ascertain whether the Service member received a medical assessment, was prescribed appropriate medication, or is undergoing current treatment.

6. The Service member may suffer from depression prior to, during, or after deployment and may be at risk for post-traumatic stress disorder. Studies indicate that males who are depressed are at higher risk of using violence in their personal relationships. If the Service member presents symptoms of depression, the clinician should ascertain whether the Service member has received a medical assessment, was prescribed appropriate medication, or is undergoing current treatment.

c. Treatment Modalities. Clinical treatment may be provided in one or more of these modalities as appropriate to the situation:

(1) Group Therapy. Group therapy is the preferred mode of treatment for domestic abusers because it applies the concept of problem universality and offers opportunities for members to support one another and learn from other group members' experiences.

(a) The decision to assign an individual to group treatment is initially accomplished during the clinical assessment process; however, the group facilitator(s) should assess the appropriateness of group treatment for each individual on an ongoing basis.

(b) The most manageable maximum number of participants for a domestic abuser treatment group with one or two facilitators is 12.

(c) A domestic abuser treatment group may be restricted to one sex or open to both sexes. When developing a curriculum or clinical treatment agenda for a group that includes both sexes, the clinician should consider that the situations in paragraphs 4c(1)(c)1 through 4c(1)(c)3 are more likely to occur in a group that includes both sexes.

1. Treatment-disruptive events such as sexual affairs or emotional coupling.

2. Jealousy on the part of the non-participant victim.

3. Intimidation of participants whose sex is in the minority within the group.

(d) A group may have one or two facilitators; if there are two facilitators, they may be of the same or both sexes.

(2) Individual Treatment. In lieu of using a group modality, approaches may be applied in individual treatment if the number of domestic abusers at the installation entering treatment is too small to create a group.

(3) Conjoint Treatment with Substance Abusers. When small numbers of both domestic abusers and substance abusers make separate treatment groups impractical, therapists should consider combining abusers into the same group because co-occurrence of domestic abuse and substance abuse has been documented in scientific literature and the content for clinical treatment of domestic abuse and substance abuse is very similar. When domestic abusers and substance abusers are combined into the same group, the facilitator(s) must be certified in substance abuse treatment as well as meeting the conditions in section 5 of this enclosure.

(4) Conjoint Treatment of Victim and Abuser. Domestic abuse in a relationship may be low-level in severity and frequency and without a pervasive pattern of coercive control.

(a) Limitations on Use. Conjoint treatment may be considered in such cases where the abuser and victim are treated together, but **only if all** of these conditions are met:

1. Each of the parties **separately and voluntarily** indicates a desire for this approach.
2. Any abuse, especially any violence, was infrequent, not severe, and not intended or likely to cause severe injury.
3. The risk of future violence is periodically assessed as low.
4. Each party agrees to follow safety guidelines recommended by the clinician.
5. The clinician:
  - a. Has the knowledge, skills, and abilities to provide conjoint treatment therapy as well as treat domestic abuse.
  - b. Fully understands the level of abuse and violence and specifically addresses these issues.
  - c. Takes appropriate measures to ensure the safety of all parties, including regular monitoring of the victim and abuser, using all relevant sources of information. The clinician will take particular care to ensure that the victim participates voluntarily and without fear and is contacted frequently to ensure that violence has not recurred.

(b) Contra-indications. Conjoint treatment will be suspended or discontinued if monitoring indicates an increase in the risk for abuse or violence. Conjoint treatment will **not** be used if one or more of these factors are present:

1. The abuser:
  - a. Has a history or pattern of violent behavior and/or of committing severe abuse.
  - b. Lacks a credible commitment or ability to maintain the safety of the victim or any third parties. For example, the abuser refuses to surrender personal firearms, ammunition, and other weapons.

2. Either the victim or the abuser or both:

a. Participates under threat, coercion, duress, intimidation, or censure, and/or otherwise participates against his or her will.

b. Has a substance abuse problem that would preclude him or her from substantially benefiting from conjoint treatment.

c. Has one or more significant mental health issues (e.g., untreated mood disorder or personality disorder) that would preclude him or her from substantially benefiting from conjoint treatment.

(5) Couple's Meetings. Periodic case management meetings with the couple, as opposed to the ongoing conjoint therapy of a single victim and abuser, may be used **only** after the clinician (or clinicians) has made plans to ensure the safety of the victim. All couples meetings must be structured and co-facilitated by the clinician(s) providing treatment to the abusers and support for the victims to ensure support and protection for the victims.

d. Treatment Contract. Properly informing the abuser of the treatment rules is a condition for treating violations as a risk management issue. The clinician will prepare and discuss with the abuser an agreement between them that will serve as a treatment contract. The agreement will be in writing and the clinician will provide a copy to the abuser and retain a copy in the treatment record. The contract will include:

(1) Goals. Specific abuser treatment goals, as identified in the treatment plan.

(2) Time and Attendance Requirements. The frequency and duration of treatment and the number of absences permitted.

(a) Clinicians may follow applicable State standards specifying the duration of treatment as a benchmark unless otherwise indicated.

(b) An abuser may not be considered to have successfully completed clinical treatment unless he or she has completed the total number of required sessions. An abuser may not miss more than 10 percent of the total number of required sessions. On a case-by-case basis, the facilitator should determine whether significant curriculum content has been missed and make-up sessions are required.

(3) Crisis Plan. A response plan for abuser crisis situations (information on referral services for 24-hour emergency calls and walk-in treatment when in crisis).

(4) Abuser Responsibilities. The abuser must agree to:

(a) Abstain from all forms of domestic abuse.

(b) Accept responsibility for previous abusive and violent behavior.

- (c) Abstain from purchasing or possessing personal firearms or ammunition.
- (d) Talk openly and process personal feelings.
- (e) Provide financial support to his or her spouse and children per the terms of an agreement with the spouse or court order.
- (f) Treat group members, facilitators, and clinicians with respect.
- (g) Contact the facilitator prior to the session when unable to attend a treatment session.
- (h) Comply with the rules concerning the frequency and duration of treatment, and the number of absences permitted.

(5) Consequences of Treatment Contract Violations. Violation of any of the terms of the abuser contract may lead to termination of the abuser's participation in the clinical treatment program.

- (a) Violations of the abuser contract may include, but are not limited to:
  - 1. Subsequent incidents of abuse.
  - 2. Unexcused absences from more than 10 percent of the total number of required sessions.
  - 3. Statements or behaviors of the abuser that show signs of imminent danger to the victim.
  - 4. Behaviors of the abuser that are escalating in severity and may lead to violence.
  - 5. Non-compliance with co-occurring treatment programs that are included in the treatment contract.

(b) If the abuser violates any of the terms of the abuser contract, the clinician or facilitator may terminate the abuser from the treatment program; notify the command, civilian criminal justice agency, and/or civilian court as appropriate; and notify the victim if contact will not endanger the victim.

(c) The command should take any action it deems appropriate when notified that the abuser's treatment has been terminated due to a contract violation.

(6) Conditions of Information Disclosure. The circumstances and procedures, in accordance with applicable laws, regulations, and policies, under which information may be disclosed to the victim and to any court with jurisdiction.



(a) Past, present, and future acts and threats of child abuse or neglect will be reported to the member's commander; child protective services, when appropriate; and the appropriate military and/or civilian law enforcement agency in accordance with applicable laws, regulations, and policies.

(b) Recent and future acts and threats of domestic abuse will be reported to the member's commander, the appropriate military and/or civilian law enforcement agency, and the potential victim in accordance with applicable laws, regulations, and policies.

(7) Complaints. The procedures according to which the abuser may complain regarding the clinician or the treatment.

e. Treatment Outside the FAP. If the abuser's treatment is provided by a clinician outside the FAP, the FAP clinical service provider will follow procedures in accordance with relevant laws, regulations, and policies regarding the confidentiality and disclosure of information. FAP may not close an open FAP case as resolved if the abuser does not consent to release of information from the outside provider confirming goal achievement, treatment progress, or risk reduction.

f. Criteria for Evaluating Treatment Progress and Risk Reduction. The FAP clinical service provider will assess progress in treatment and reduction of risk consistent with volume 1 of this manual. If a risk factor is not addressed within the FAP but is being addressed by a secondary clinical service provider, the FAP clinical service provider will ascertain the treatment progress or results in consultation with the secondary clinical service provider. Treatment progress should be assessed periodically using numerous sources, especially, but not limited to, the victim. In making contact with the victim and in using the information, promoting victim safety is the priority. Progress in clinical treatment and risk reduction is indicated by a combination of:

(1) Abuser Behaviors and Attitudes. An abuser is demonstrating progress in treatment when, among other indicators, he or she:

(a) Demonstrates the ability for self-monitoring and assessment of his or her behavior.

(b) Is able to develop a relapse prevention plan.

(c) Is able to monitor signs of potential relapse.

(d) Has completed all treatment recommendations.

(2) Information From the Victim and Other Relevant Sources. The abuser is demonstrating progress in treatment when the victim and other relevant sources of information state any one or combination of the following: That the abuser has:

(a) Ceased **all** domestic abuse.

- (b) Reduced the frequency of non-violent abusive behavior.
- (c) Reduced the severity of non-violent abusive behavior.
- (d) Delayed the onset of abusive behavior.
- (e) Demonstrated the use of improved relationship skills.

(3) Reduced Ratings on Risk Assessment Variables that are Subject to Change. The abuser has successfully reduced risk when the assessment of his or her risk is rated at the level the Military Service has selected for case closure.

## 5. PERSONNEL QUALIFICATIONS

a. Minimum Qualifications. All personnel who conduct clinical assessments of and provide clinical treatment to domestic abusers must have these minimum qualifications:

- (1) A master's or doctoral-level human service and/or mental health professional degree from an accredited university or college.
- (2) The highest license in a State or clinical license in good standing in a State that authorizes independent clinical practice.
- (3) 1 year of experience in domestic abuse and child abuse counseling or treatment.

b. Additional Training. All personnel who conduct clinical assessments of and/or provide clinical treatment to domestic abusers must undergo this additional training:

(1) Within 6 months of employment, orientation into the military culture. This includes training in the Service rank structures and military protocol.

(2) A minimum of 15 hours of continuing education units within every 2 years that are relevant to domestic abuse and child abuse. This includes, but is not limited to, continuing education in interviewing adult victims of domestic abuse, children, and domestic abusers, and conducting treatment groups.

(3) Service FAP Managers must develop policies and procedures for continued education with clinical skills training that validates clinical competence, and not rely solely on didactic or computer disseminated training to meet continuing education requirements.

## 6. QUALITY ASSURANCE

a. Quality Assurance Procedures. The FAP Manager must ensure that clinical intervention undergoes these quality assurance procedures:

(1) A quarterly peer review of a minimum of 10 percent of open clinical records that includes procedures for addressing any deficiencies with a corrective action plan

(2) A quarterly administrative audit of a minimum of 10 percent of open records that includes procedures for addressing any deficiencies with a corrective action plan.

b. FAC Responsibilities. The installation FAC will analyze trends in risk management, develop appropriate agreements and community programs with relevant civilian agencies, promote military interagency collaboration, and monitor the implementation of such agreements and programs on a regular basis consistent with volume 1 of this manual.

c. Evaluation and Accreditation Review. The installation domestic abuse treatment program will undergo evaluation and/or accreditation every 4 years, including an evaluation and/or accreditation of its coordinated community risk management program consistent with volume 1 of this manual.

## GLOSSARY

### PART I. ABBREVIATIONS AND ACRONYMS

CCSM	clinical case staff meeting
DoDI	DoD Instruction
FAC	Family Advocacy Committee
FAP	Family Advocacy Program
R&R	rest and recuperation
UCMJ	Uniform Code of Military Justice
USD(P&R)	Under Secretary of Defense for Personnel and Readiness

### PART II. DEFINITIONS

Unless otherwise noted, the following terms and their definitions are for the purpose of this volume.

abuser. An individual adjudicated in a military disciplinary proceeding or civilian criminal proceeding who is found guilty of committing an act of domestic violence or a lesser included offense, as well as an individual alleged to have committed domestic abuse, including domestic violence, who has not had such an allegation adjudicated.

abuser contract. The treatment agreement between the clinician and the abuser that specifies the responsibilities and expectations of each party. It includes specific abuser treatment goals as identified in the treatment plan and clearly specifies that past, present, and future allegations and threats of domestic abuse and child abuse or neglect will be reported to the active duty member's commander, to local law enforcement and child protective services, as appropriate, and to the potential victim.

clinical case management. Defined in volume 1 of this manual.

CCSM. Defined in volume 1 of the manual.

clinical intervention. Defined in volume 1 of this manual.

domestic abuse. Defined in Reference (c).

domestic violence. Defined in Reference (c).

FAP Manager. Defined in Reference (b).

incident determination committee. Defined in Reference (b).

intimate partner. Defined in Volume 2 of DoD Manual 6400.01 (Reference (h)).

risk management. Defined in volume 1 of this manual.

severe abuse. Defined in Reference (h).

unrestricted report. Defined in Reference (c).