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Article

STORIES ABSENT FROM THE COURTROOM: RESPONDING TO DOMESTIC VIOLENCE IN THE CONTEXT OF HIV AND AIDS[a1]

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Silence surrounds the connection between domestic violence and HIV/AIDS. The presence of HIV/AIDS dramatically impacts domestic violence survivors' needs and demands a reconceptualization of current responses to domestic violence. This Article aims to illuminate the problem of domestic violence in the context of HIV/AIDS and to prompt further development of legal response systems. Specifically, this Article brings together the worlds of law, public health, and women's lived experiences to argue for recognizing and responding to domestic violence in the context of HIV/AIDS in the United States. Utilizing accounts of clients' experiences and data from public health studies, this Article sets forth eight categories of HIV/AIDS-related domestic violence: repercussions from partner notification, use of knowledge of a partner's HIV status to exert control, interference with medical treatment, inability to negotiate condom use, sexual assault, infidelity, intentional infection with HIV, and other ways survivors are at risk. The real-life stories in these categories show how HIV/AIDS changes the nature and consequences of intimate partner violence. Currently, the prevalence of the role of HIV/AIDS in domestic violence is not revealed in civil protection order cases because of the public nature of the proceedings and clients' concerns about discrimination. With the absence of these stories from the courtroom, litigants lose the therapeutic benefits of storytelling and receive less effective relief than appropriate because judges do not understand the events and are not able to award remedies tailored to the actual experiences of violence.The ***1158** previously unrecognized voices of those who suffer at the intersection of HIV/AIDS and domestic violence can serve to inspire procedural and substantive legal changes as well as specific response mechanisms. Procedural changes would make courtrooms safer places for revealing highly sensitive, socially stigmatizing, and otherwise confidential information. Substantive changes in domestic violence protection order laws would address complex situations of intimate partner violence, and judicial remedies could target HIV-related domestic violence. Through greater understanding of HIV/AIDS-related domestic violence, lawyers would serve as better advocates for their clients and would address their multiple needs. Finally, domestic violence response mechanisms need to employ coordinated interventions to provide lifesaving medical and legal care to survivors with HIV/AIDS and to those whose abusive partners have HIV/AIDS.

*1160 Introduction

Attorneys representing survivors[1] of domestic violence[2] in civil protection order cases are seeing an alarming trend that is not revealed in court: intimate partner violence in the context of HIV and AIDS. Too often, either party's HIV or AIDS status[3] plays a central role in the violence, although clients do not want to speak about this in court. I represent domestic violence survivors and direct a domestic violence clinic in which I supervise students who represent clients.[4] One clinic client, for example, described how her boyfriend ***1161** flushed her medication down the toilet while saying, "You're going to die anyway."[5] To understand the extent of the physical harm, the psychological hurtfulness, and the violence of this act requires knowing that the client is HIV-positive and that her boyfriend had destroyed her HIV medications. During representation, some of my clients have discovered that they have contracted HIV following sexual assault by an abusive partner. Other

clients have revealed that their partners threatened to publicize the survivors' HIV status if the clients attempted to leave the relationship. Survivors' stories make it evident that domestic violence can be a risk factor for HIV infection, and HIV/AIDS status can change the nature and consequences of violent acts in abusive relationships.

Domestic violence is about power and control,[6] and in an abusive relationship, the use of HIV status can be an effective way to exercise control. For all of the clients whose stories are described in this Article, HIV/AIDS was central to the violence and harms they suffered. Whether because of an escalation of violence after a victim informed her partner of her HIV-positive status, an abusive partner's ***1162** interference with an HIV-positive person's medical treatment, the victim's inability to insist on condom use, sexual assault resulting in infection, or other problems, domestic violence and HIV status are all too often inextricably linked. While the relevance of HIV in intimate partner violence is not typically part of the story relayed to the fact-finder, it is a phenomenon with which domestic violence survivors and their lawyers are all too familiar. And although a great deal of my client counseling involves talking about issues pertinent to HIV, my clients have chosen not to share the details of the HIV-related violence in court out of valid concerns about privacy, social stigma, and discrimination. In courtrooms across America,[7] one can spend many days observing protection order cases and not hear a reference to the role of HIV or AIDS in the violence.

In the last decade, those in public health and medical professions have begun to recognize the connection between domestic violence and HIV/AIDS. While Dr. Antonia C. Novello was the U.S. Surgeon General, she wrote, "Today, we face two major public health epidemics that represent particular dangers to women. One is the human immunodeficiency virus (HIV) epidemic, and the other is domestic violence. Although these two epidemics might seem unrelated, they are intertwined in ways that pose serious challenges to the health care community."[8] The intersection of the "twin epidemics"[9] of domestic violence and HIV/AIDS is an unexamined problem in the legal response to domestic violence in the United ***1163** States,[10] and the lack of awareness of this occurrence inhibits the development of more appropriate advocacy responses. The multiple motivations for raising awareness and beginning to address this problem include not only the personal stories of survivors of domestic violence, but also concerns about access to justice and the systemic issues that keep these stories out of court and prevent litigants from receiving needed relief.

Part I of this Article analyzes eight situations in which HIV/AIDS influences the dynamics of intimate partner violence and details accounts not told in court. Part II explores the reasons silence surrounds HIV-related violence, describing clients' struggle with revealing otherwise confidential information and identifying the continued stigma, fear, and misunderstanding of HIV and AIDS. Because of the inability to fully describe experiences in court, survivors receive less effective relief than appropriate and forgo the therapeutic benefits of storytelling.

The current legal response, which fails to take account of the role of HIV/AIDS status, reflects an oversimplified understanding of domestic violence. If the frame shifted and HIV/AIDS were seen as relevant to someone's experience of domestic violence, how would the legal system's response improve? As an answer to that question, Part III recommends procedural changes to the legal system and the use of already-existing procedural mechanisms to create greater opportunities for revealing confidential information in court. This Part also suggests how recognition of the intersection between HIV/AIDS and domestic violence could lead to substantive changes in the law, including expanded statutory definitions of domestic violence and additional grounds for seeking protection orders. Lawyers and judges who hear and value survivors' stories will be able to better respond to individuals' experiences, resulting in remedies that would address the role of HIV/AIDS in intimate partner abuse. Part III advises adding a medical intervention component to centralized domestic violence centers that coordinate the civil and criminal justice systems' responses, along with recommending training for judges and lawyers. Given the urgent health and safety issues implicated by HIV-related domestic abuse, these initiatives are imperative.

***1164 I. HIV/AIDS and Intimate Partner Violence**

A. Public Attention to Women with HIV/AIDS in America

When AIDS was identified in the early 1980s,[11] the world had no way of comprehending the disease's future or its far-reaching impact. During the 1980s and through the 1990s, the AIDS epidemic primarily spread among homosexual men,[12] with women initially comprising a small fraction of AIDS cases in the United States.[13] Although both men and women were contracting HIV at alarmingly high rates, early American health and media responses focused on men.[14] AIDS, however, was never consigned to only one population.[15] In 1991, the Centers for Disease Control and Prevention's definition of AIDS did not include infections and disease manifestations characteristic of women with HIV, and research indicates that many women with HIV died without meeting the criteria for an AIDS diagnosis.[16] A 1991 full-page advertisement in The New York Times called attention to how women had been disregarded in the response to the AIDS epidemic. The advertisement read: "Women Don't Get AIDS, They Just Die From ***1165** It."[17] Even as women represented an increasing percentage of new AIDS cases, women continued to receive inadequate attention in the response to HIV/AIDS.[18]

HIV continues to spread in the United States, and the pandemic has wrought devastation in other parts of the world.[19] The Centers for Disease Control and Prevention conservatively estimates that more than one million persons are living with HIV in the United States, one-quarter of whom are undiagnosed and unaware of their infection,[20] and approximately 450,000 people currently have AIDS.[21] The AIDS crisis continues in the nation's capital, as shown by a recent study calling HIV in the District of Columbia a "modern epidemic."[22] In the District, one in twenty residents is HIV-positive, and one in fifty is living with AIDS.[23] Over the past twenty-five years, ***1166** substantial medical progress has been made, and people are now living with HIV as opposed to suffering the previously assumed "death sentence"; however, timely intervention and closely monitored treatment make all the difference in a person's prognosis.

Today, women are infected with HIV at ever-growing rates, and heterosexual transmission of HIV is the fastest-growing mode for infection among women.[24] Low-income women of color are particularly overrepresented in new transmissions,[25] with African American women being the fastest-growing group of people infected with HIV.[26] The "feminization" of the epidemic and gender-specific barriers are important considerations in developing services to prevent and respond to HIV/AIDS.[27] In light of the often gendered ***1167** nature of intimate partner violence and the role HIV/AIDS plays in many violent relationships, society is faced with human rights issues that cannot be ignored.

B. The Intersection of HIV/AIDS and Intimate Partner Violence

The presence of HIV or AIDS in an abusive relationship can change how a domestic violence survivor experiences abuse.[28] HIV/AIDS often influences the nature of violent acts and the type of power and control exerted and can transform the effect of violence by elevating the level of danger and the consequences of actions.[29] Many women who are abused by an HIV-positive intimate partner report that HIV status is used as part of the violence.[30] Women who are HIV-positive similarly report that they experience domestic violence that is directly related to their HIV status.[31] In addition, domestic ***1168** violence victims are at an "increased risk of HIV infection, even after their own risky behavior is taken into account,"[32] which "adds to and underscores the level of physical danger they face."[33]

This Section includes examples from my clients' lives, descriptions of the ways HIV/AIDS status is used in domestic violence, and quotes from interviews conducted for social science and health studies to bring this body of research into the legal context. Eight categories of HIV-related violence are used to further elucidate HIV/AIDS status in domestic violence: (1) partner notification; (2) use of knowledge of a partner's HIV status to exert control; (3) interference with medical treatment; (4) inability to negotiate condom use; (5) sexual assault; (6) infidelity; (7) intentional infection with HIV; and (8) other ways survivors are at risk.[34] Violence does not occur in one set way; a domestic violence survivor may experience ***1169** one or multiple combinations of the forms of HIV-related violence identified in this Section.

1. Partner Notification[35]

One client spoke of the emotional pain she felt, trying to comprehend the terrifying news that she was HIV-positive and at the same time struggling to deal with her boyfriend's anger at her when she told him the news.

She told me that he was probably scared, but that didn't make his shouted insults and threats hurt less.[36]

Public health professionals investigating HIV disclosure-related interpersonal violence conclude that "HIV infection is an important, and heretofore unrecognized, risk factor for violence against women."[37] Women experiencing intimate partner violence report an increase in physical violence and emotional attacks after they reveal their HIV-positive diagnoses to their abusive partners.[38]

***1170** Many women with HIV fear notifying their partners of their status. One woman described her hesitancy:

> I was scared to tell him. That's why I waited for awhile. I was gonna send a letter to him so I wouldn't be there cause he done hit me before . . . [.] He gets mad and then says he'll hit me, he get to hollering at me and stuff like that. That scares me cause I know next thing, the next step he would hit me . . . .[39]

Another woman similarly reported, "They [the clinic] want me to come out and tell him. I keep trying to tell them, 'I'll send him down here let y'all tell him. Don't say my name, cause that man is violent.'"[40] A Baltimore, Maryland, study found that forty-five percent of health providers had female patients who feared that disclosing their HIV status would lead to intimate partner violence.[41] It is also likely that the perpetrator may blame the woman for infecting him or for contracting HIV through sex or needle-related drug activity outside of the relationship.[42]

Women report a range of demeaning and violent responses to partner notification. One woman described her partner's reaction: "One day, he kicked the TV . . . and knocked up all the furniture, and took soap and wrote 'AIDS bitch' on the mirror."[43] Another woman explained the increased violence she experienced: "He was abusive before I told him I was HIV-positive, and afterwards, well, the beatings got worse and more . . . they happened more regularly. I say that because I remember him making the statement, 'I should kill you since you are trying to kill me.'"[44] Other reports confirm that "[w]omen have been shot, physically and verbally abused, rejected, and abandoned after revealing their HIV status,"[45] and provide graphic detail:

> Patients were kicked, beaten, shot and raped and suffered knife wounds to the face. One patient broke both legs after jumping ***1171** from a third-floor window to escape being shot. The incidents of emotional abuse ranged from partners spitting on patients to threats of violence and death against both the women and their children. Some of these incidents occurred in the presence of [medical] providers.[46]

As a public health measure, many states adopted partner notification laws that require current and former sexual partners to be notified of a patient's HIV status so that they too can be tested and receive treatment.[47] However, with the advent of notification laws around the country, health professionals and domestic violence advocates grew concerned about the potential for additional violence in abusive relationships.[48] They recognized that partner notification laws needed to include an assessment of domestic violence and a more nuanced approach that would account for the risk of disclosure-related abuse.[49] Partner notification is important because a woman's delay in disclosure, combined with her hesitation or inability to insist on condom use, could lead to unprotected sex and increase the risk of transmission to an uninfected partner; however, precautions need to be taken to protect a survivor's safety during disclosure.[50]

2. Use of Knowledge of a Partner's HIV Status to Exert Control

An HIV-positive client explained that she remained in the abusive relationship because her partner convinced her that if she tried to leave, he would tell others, including her employer and residents of her apartment building, that she was HIV-positive.

As a way of exerting control over an intimate partner and coercing her to stay in a relationship, the abusive partner may threaten to publicize the woman's HIV status if she breaks off the relationship.[51] One woman reported that her abusive partner told ***1172** her, "No one else will want you now, so you'll have to stay," and, when she tried to end the relationship, he threatened that if she left, "I'll tell the world what you got."[52] Because of societal bias and prejudice, a survivor may fear the social and professional ramifications of having her HIV

status become public knowledge.[53] She is faced with choosing between safety and the potential repercussions of the abuser's retaliatory act of revealing her status to her employer, her children's school, daycare providers, friends, neighbors, and others.[54]

An abusive partner may use the knowledge of the other partner's HIV status in multiple other ways as a means to control the HIV-positive victim of violence. Some abusive partners make threats regarding the custody of children, causing an HIV-positive victim to fear that she will be denied all custody and visitation rights if she pursues legal remedies for domestic violence.[55] Other partners make ***1173** threats regarding deportation, thus wielding control by threatening to report their partners' HIV-positive status to immigration officials.[56]

3. Interference with Medical Care

A client revealed that she was HIV positive and that she took numerous medications to maintain her health. Her boyfriend had been physically abusive for some time, but the most hurtful incident, the event that finally caused her to seek help, was related to her HIV status. After her boyfriend gave her a black eye and bruised her arm, he flushed all of her HIV medications down the toilet, saying, "You're going to die anyway."[57]

An abusive partner may prevent the HIV-positive partner from obtaining medical care and from following a doctor's prescribed medical regimen. It is common to hear that a batterer destroyed medication to control a partner's health and keep her sick. Other clients have observed their partners ingesting the medication prescribed to the clients, although the partners refused to be tested for HIV/AIDS.[58] This interference with medication compromises the treatment and health of an HIV-positive individual.[59]

***1174** Regular health care for HIV-positive women is crucial to their well-being, but doctors have found that abuse commonly interferes with an HIV-positive woman's access to and compliance with treatment.[60] Some abusive partners refuse to allow medical or social service workers to enter the home.[61] Even more disturbing, some clients are literally locked inside their homes by their abusers[62] and are unable to leave for any reason, including medical appointments. The frequency of medical appointments may fuel suspicion and tension in the home, as an abusive partner may not believe the HIV-positive partner actually has a medical need for the appointments, suspecting she is going elsewhere.[63] Thus, it is important for health care providers to understand the ways in which intimate partner abuse can prevent and interfere with treatment.

Domestic violence often diminishes a survivor's ability to seek health care initially and to continue obtaining regular care. With these multiple barriers, the consequences of an HIV-positive domestic violence survivor's inability to access medical care are severe, given the lethal nature of untreated HIV/AIDS.

***1175** 4. Inability to "Negotiate" Condom Use[64]

A teenage client dating an older man was initially flattered by his attention, but he soon became verbally and physically abusive. When she asked him to use a condom, he refused. In the weeks leading up to the protection order hearing, this young client learned that she was HIV-positive and that the respondent had infected her.

An abusive partner may respond to requests to use a condom with threats or physical violence. One woman recounted her partner's accusations of infidelity and threats to her life after she requested that he use a condom:
He kept saying, "Who the hell is he? Who the hell is he?" Accusing me that I was with somebody else. He kept telling me I was messing around with somebody else. He'd say, "Tell me who he is. Tell me. I hope this guy is worth dying for. I hope he's worth dying for."[65]
This woman reported that it "was easier to engage in unprotected sex" with her husband than to insist on condom use, even though she knew he used drugs and suspected him of having concurrent partners.[66]

Condoms are currently the most effective means of preventing transmission of HIV, but because condom use requires male cooperation, it is often not fully within a woman's control.[67] Power imbalances in relationships and gender inequality are problematic because "condom use is a sexual behavior that is clearly under the control of men and is embedded in a socially sanctioned inequality ***1176** between partners."[68] Additionally, women

report violent responses to their attempts to use female condoms.[69] For example, one woman reported that when she tried to use a female condom, her partner knocked two of her teeth out and beat her, resulting in her hospitalization.[70] A woman's inability to insist on the use of condoms will increase her risk of heterosexually transmitted HIV from an HIV-positive partner.

Women who have experienced violence in their relationships recognize that the question of condom use creates additional opportunities for conflict and potential abuse. A woman's ability to negotiate condom use is diminished by the fear of or the actual experience of physical, psychological, and sexual abuse, which is the reality of her daily experience in her relationship.[71] Fear of a partner's anger in response to requests to use condoms turns out to be a largely accurate predictor of condom nonuse,[72] and there is a significant correlation between physical and sexual violence and inconsistent condom use.[73] In a study of 423 women in heterosexual relationships, researchers found that "[c]hronicity of abuse was significantly related to condom use."[74] For women who are in relationships marked by abuse, the risks of introducing condoms "may actually be much more immediate than the risk of contracting HIV."[75] Based on the immediacy of danger, these women self-censor ***1177** and do not take self-protective actions for their long-term health. Across studies, women in abusive relationships frequently reported that they were not in a position to insist on monogamy or condom use, and that they were unable to refuse sex, which placed them at risk for AIDS exposure.[76]

5. Sexual Assault

On multiple occasions, my clients who were raped by their intimate partners have discovered that they were HIV-positive as we prepared for trial in civil protection order cases. One client hesitated as she began telling me about the violence, her speech halting and breaking. She paused after relaying the details of the sexual assault and asked, "Was that rape?" I nodded to affirm her question, and she proceeded to tell me the medical news she had just received about being HIV-positive.

The high rates of sexual abuse in intimate partner violence put victims at greater risk for contracting HIV.[77] Research shows that women who are physically and sexually assaulted face an increased risk of HIV infection.[78] One woman reported her experience with her HIV-positive husband: "[H]e forced me to have sex whether I liked it or not, even up until the time he died."[79] Sexual violence often accompanies other forms of physical violence in battering relationships.[80] During a relationship in which there is domestic ***1178** violence, at least sixty percent of abused women are sexually assaulted by their partners,[81] and almost half of all battered women are raped by their partners.[82] The majority of women who are raped by an abusive partner experience multiple sexual assaults by this partner during the relationship,[83] and women are particularly at risk for HIV infection from HIV-positive perpetrators.

6. Infidelity

A client's husband was openly committing adultery. She pleaded with him to be tested and said she didn't want to have sexual intercourse, but he rejected her plea. She later tested positive for HIV.

In both violent and nonviolent relationships in which one partner is not monogamous,[84] there are risks of HIV infection; however, a battered woman may fear the repercussions of confronting her abusive partner about his fidelity.[85] She may continue to have sexual intercourse with her partner because she fears that if she refuses, asks that he be tested for sexually transmitted diseases, or insists on using protection during sexual intercourse, he may respond with physical violence.[86] If her partner admits to having been unfaithful, he may maintain that it was an isolated event and that he used protection, and her fears about potential violence may inhibit her ability to express concern about his truthfulness and about her own health.[87] Research further indicates that, even in the face of concerns about HIV transmission, "she may feel certain that if she confronts her ***1179** husband, the physical and emotional consequences will be serious and immediate."[88]

7. Intentional Infection with HIV

In some cases, HIV transmission may result from rape and the refusal to use a condom, but the infecting partner may not intend the result of HIV infection. In other cases, the context and surrounding words make it clear that infection was intentional.[89] One HIV-infected woman reported that her partner confessed to infecting her

deliberately, explaining to her, "I only did it because I love you so much."[90] An abusive partner may engage in many actions to keep the survivor from leaving.[91] Willfully infecting a partner with HIV is an extreme attempt to lock the other partner into the relationship by making the partner ostensibly undesirable to others. Intentionally infecting a partner in a relationship that has power and control dynamics is the ultimate expression of control.

8. Other Ways Survivors Are at Risk

A woman in her sixties, whose husband was infected with AIDS through a blood transfusion, sought representation after being married for nearly forty years. As her husband developed health problems and struggled with sickness, and as she remained healthy, he became angry that she was not also sick and he began to lash out at her.

This is yet another example of many clients' stories that reveals the relationship between HIV and partner violence. Other abusive partners exert power by threatening to abandon a sick partner.[92] For some women who experience intimate partner violence, the partner's coercion includes involving her in behaviors that expose her to greater risk of contracting HIV. For example, an abusive partner may coerce or force a woman to engage in illicit drug use and sex ***1180** work, both of which carry substantial risk of contracting HIV.[93] One participant in a study on the links between HIV risk and domestic violence reported:

> The guy I was going out with introduced me to drugs. He had me out there selling my body to get all the drugs and stuff for us, you know? He got to beating on me because I didn't want to get out there no more in the streets doing it, and that's when he broke my cheekbone and everything. That's when I got infected by him because he kept forcing me to have sex. I felt bad about myself, weak-minded, you know? Because I got into drugs and prostitution and then I got myself infected.[94]

Other survivors report that they become high or pass out from drug use and are then vulnerable to sexual abuse.[95]

The prior individual accounts and examples of the intersection of domestic violence and HIV/AIDS are provided to illuminate this connection, bring social and legal recognition to this phenomenon, question how to overcome the legal system's impasse at addressing this injury, and guide the search for possibilities for legal change.[96] The examples provide insight into the violence many women experience daily. The public is generally unaware of this troubling problem, however, because the courtroom environment and issues of stigma prevent people from testifying about HIV-related aspects of violence. These concerns are discussed in detail in Part II.

*1181 II. Stories Absent from the Courtroom

A. Domestic Violence Survivors' Storytelling as Impetus for Change in the Legal System

The legal system has only in recent decades responded to domestic violence in a meaningful way. Against the backdrop of the law's failure to condemn violence against women, the women's movement of the 1960s and 1970s revolutionized the state's response to domestic violence.[97] The survivor's movement was based on the significance of "breaking silences and speaking out about abuse."[98] In consciousness-raising groups, women came together and created safe spaces to discuss and compare their experiences, learn from each other, and identify the societal forces that were complicit in the violence they experienced.[99] In "speakouts," domestic violence survivors who had been silenced spoke for the first time,[100] informing the public of the commonality and harms of violence against women. Judith Herman reflects, "[W]e realized the power of speaking the unspeakable and witnessed firsthand the creative energy that is released when the barriers of denial and repression are lifted."[101] This process informed the movement's agenda, as feminist shelter workers, survivors of violence, academics, and lawyers combined efforts and raised awareness of domestic violence, created a network of safe ***1182** houses and shelters, and achieved tremendous victories by enacting legal protections for battered women.[102]

The movement demanded that violence in the home be treated as seriously as stranger violence, and each state passed legislation that criminalized acts of domestic violence.[103] By the early 1990s, all states had enacted statutes addressing domestic violence that made civil protection orders and enforcement mechanisms available.[104] Specialized units targeting domestic violence were created in courts, social service agencies, police departments, and prosecutor's offices.[105] Although dramatic strides have been made, advocates are still searching for effective responses to and interventions in the complex social and legal problem of domestic violence.

***1183** A legislative and judicial response to domestic violence now holds sway where none existed before.[106] Police officers, domestic violence hotlines, and safety advocates instruct survivors to turn to the protection order process for assistance.[107] The protection order remedy has proven key to intervening in domestic violence, with studies showing that "[p]rotection orders, when properly drafted and enforced, are effective in eliminating or reducing domestic abuse."[108] ***1184** Because the legal system is currently the primary avenue for assistance,[109] the system must ensure that courts respond to individual survivors' experiences and that courts are effective places for survivors of various types of domestic violence to seek assistance. Now that many jurisdictions have dedicated domestic violence courtrooms, women are expected to speak out and reveal information, but the courtroom is a very different environment from the safe space of the consciousness-raising group. In the judicial system's response to domestic violence, litigants are asked to reveal the most deeply personal and sensitive matters in a highly public forum.

Although clients, social scientists, and medical professionals confirm the problem of the use of HIV/AIDS status in abusive relationships,[110] domestic violence courtrooms do not reflect the experience of the litigants. Petitioners seeking the court's protection are reluctant to reveal this personal information because of concerns about stigma, and the law does not recognize the interconnectedness of HIV/AIDS and domestic violence.

B. Stories of HIV-Related Domestic Violence, Previously Unheard

Concerns about stigma and issues of isolation are common among both domestic violence survivors[111] and HIV-positive ***1185** individuals, and inhibit survivors from openly speaking about their experiences of HIV-related domestic violence. Social stigmatization resulting from public knowledge of an individual's HIV status affects the decision to be tested,[112] and those who have experienced HIV-related intimate partner violence may have feelings of isolation and shame and may fear rejection and abandonment if others learn their status.[113] Real and perceived stigmatization prevents many people from openly discussing their HIV status when surrounded by members of the public, such as in a courtroom.[114] Further, silence on the subject of HIV-related violence can have many detrimental effects. One consequence of silence is the loss of the therapeutic benefit of telling one's story to a judicial authority.[115]

1. Social Stigma of HIV/AIDS

Discrimination against individuals based on their HIV status runs rampant. Despite public health campaigns to dispel myths about the spread of HIV, many people harbor unwarranted fears and discriminate based on HIV status. For example, any person the community knows to be HIV positive may have difficulty finding or keeping housing.[116] HIV-infected teachers have had to litigate for the ***1186** right to teach, and HIV-positive students have had to litigate for the right to attend public schools.[117] It is easy to find examples of hate speech based on HIV status and of families being ostracized from communities.[118] Immigrants may fear that others' knowledge of their positive HIV or AIDS status will result in deportation.[119] Employment discrimination and hostility toward those who are HIV positive are evident in reports of employers firing HIV-positive workers and requiring that employees be tested for HIV and AIDS as a condition of initial employment, continuing employment, or promotion.[120] HIV-positive individuals have also been denied insurance coverage, resulting in a tremendous financial burden.[121]

Courts have recognized the social stigma, discrimination, and harassment that may result from public knowledge of an individual's AIDS infection, with one court remarking, "It is unfortunate that public understanding of this disease has changed so little in the intervening years. But, although AIDS hysteria may

have subsided somewhat, there still exists a risk of much harm from nonconsensual dissemination of the information that an individual is inflicted with ***1187** AIDS."[122] Although courts have acknowledged harms resulting from stigma, they have not recognized and responded to the consequences of such discrimination in the domestic violence legal system.

2. The Impact of Stigma in Dissuading Testimony

While representing clients and supervising law student representation, I frequently witness clients' profound concerns about stigma and apprehension about proceeding in court. When I first meet clients at the Domestic Violence Intake Center in Washington, D.C.,[123] clients sometimes lean in and, in a hushed voice, share details of how HIV status is relevant to their abuse. Clients also confide in the student attorneys I supervise. The students then come to me, cup their hands around their mouths as they whisper what their new clients have revealed, and ask, "What do we do?"

With each client, the attorney and client strategize about what to include in the petition and what testimony to present to the judge. The answer typically turns on the presence of other individuals in the courtroom. I explain that the courtroom is open to the public, with attorneys and litigants waiting for their cases to be called, and other members of the public are free to view the proceedings. This is the case across America; almost all protection order hearings occur in formal courtroom proceedings in open court.[124] The environment of ***1188** the courtroom and the stigma borne by persons with HIV/AIDS combine to prevent petitioners from sharing their stories in court.[125]

With approximately 4,400 civil protection order cases handled by two courtrooms in the District of Columbia each year, the dockets are sizable and the courtrooms are full.[126] Temporary protection order cases[127] previously could be heard in a large courtroom or in a magistrate judge's smaller courtroom that had only enough space for the judge, a clerk, a lawyer, and the petitioner. When clients heard that they could be in a small courtroom, they often volunteered that they would like to tell the judge the full story, including the elements of violence related to HIV/AIDS. Clients overwhelmingly seemed to want to tell the judge their stories and wanted the judge to fully understand their situation, but they also wanted to protect their privacy. We often devised two plans: one for the small courtroom and one for the large courtroom. But this smaller courtroom is no longer available, so now all petitioners are ushered into a large, formal courtroom. This is the environment in which survivors of violence are asked to tell their stories, and it is harrowing.

In one case, a client explained that she did not want her own or her partner's HIV status to be a public issue. In the complaint, therefore, we did not write, "The respondent flushed the petitioner's HIV medication down the toilet and told her she was going to die ***1189** anyway." HIV status was not mentioned in the allegations, the opposing party was not put on notice of any HIV-related aspects of violence, and the petitioner did not discuss this part of the event in her testimony.[128] But, as in many cases, what prompted the petitioner to come to the courthouse, and what hurt her most deeply, was that this act related to HIV status.

In another case, a client who had been raped by her ex-boyfriend learned that she was HIV positive, but she did not want to record this fact in the petition (a public document) nor did she wish to discuss this in a public courtroom. Would the information that the rape resulted in the petitioner contracting HIV have mattered to the judge? It likely would have. However, this aspect of the violence was too hard for the petitioner to reveal under the circumstances and structures in place, and the legal system gave her less protection than she would have gained if she had been able to tell the HIV-related aspect of her story in confidence to the judge. The protection order process left her feeling exposed or unprotected.

With the public nature of domestic violence proceedings, clients are concerned about the consequences of revealing personal information in open court. This "public" is not simply a roomful of strangers. In my experience representing clients in Washington, D.C., clients routinely see at least one person they know in the courthouse, and often see four or five. These friends, neighbors, relatives, co-workers, or distant acquaintances may be court employees, other litigants in domestic violence cases, or persons at the courthouse for other matters. In weighing the prospect of going to trial, one client said, "I don't want to talk about this in front of the whole neighborhood." I see clients struggling to answer acquaintances' question, "What are you here for?" It is a rare day when a client does not encounter someone she knows. Increasing the likelihood of encountering an

acquaintance, some jurisdictions schedule protection order court dates based on the petitioner's neighborhood or ZIP code.[129] In small communities, the courthouse is similarly a very public place.

With other members of the public present, litigants consider how revealing information about domestic violence and HIV/AIDS might negatively affect their family members, the opposing party, and ***1190** themselves; they contemplate how others might respond to the information; and they are brutally aware of the continued social stigmatization and lack of understanding about the transmission of HIV. The domestic violence courtroom is not an anonymous environment where there is little chance of encountering a neighbor, co-worker, or friend. In this branch of the court that deals with the most sensitive, personal issues, private lives are revealed.

Even for the many abuse survivors who report that they want to tell their stories in court, multiple factors make this difficult. Empirical studies show that abuse victims typically seek court protection only after they have endured severe abuse over extended time.[130] Survivors of domestic violence have often experienced high levels of control by their partner; harmful emotional, physical, and psychological abuse; resulting psychological effects of violence;[131] loss of self-esteem; and social isolation.[132] The many barriers to pursuing a protection order and coming to court include the difficulty of confronting the abuser, fear of retaliation, and questions of whether to further engage an abusive partner. The courtroom environment itself can also be traumatizing for victims of violence, because "victims are forced to tell their stories again and again, participate in lengthy, repetitive, and confusing proceedings, repeatedly face or confront their abuser, and give up even the semblance of privacy."[133] In a national survey of lawyers regarding protection orders, three- ***1191** quarters of respondents stated that the public nature of the proceedings and the related embarrassment prevented some women in their jurisdictions from pursuing relief.[134] This feeling is amplified regarding HIV/AIDS-related violence.[135]

Discrimination against HIV-positive individuals may make the public courtroom a threat and the prospect of exposing one's life in open court dangerous. Regard for the respondent's privacy interests can also discourage a petitioner from revealing the abuser's HIV status.[136] Decisions about how to resolve a case may be heavily influenced by the anticipation of discussing HIV status in the courtroom. If HIV status is intricately linked to the violence and it is impossible to explain the allegations of violence and what actually happened without discussing HIV status, the petitioner may feel forced to dismiss the case when faced with the prospect of a public trial. Some petitioners choose to settle cases and accept less comprehensive relief as opposed to going to trial. Without the ability to reveal the most harmful aspects of the violence, the petitioner may leave the courthouse without receiving meaningful and inclusive relief.

From a procedural justice perspective, the accused's ability to tell his version of the events and his sense that he is being treated with respect increases his compliance with judicial orders, including an order of protection.[137] The protection order process should be a safe ***1192** place for both parties to reveal information because both individuals may have strong interests in keeping information confidential,[138] and the survivor's future safety is implicated.

To the extent that domestic violence courts are not safe places for litigants to reveal violent experiences, including the ways in which HIV status is used as part of the violence, litigants lose the ability to vindicate their rights. Silence about family violence already masks the commonality of domestic abuse.[139] In a crowded courtroom and an unfortunate atmosphere of ongoing social stigmatization, the current court process marginalizes the context of HIV or AIDS in petitioners' histories. Intimate partner violence in the context of HIV and AIDS is not an extraordinary occurrence, it is just not spoken about publicly.

3. Loss of Therapeutic Benefit from Reporting Violence to a Judicial Authority[140]

One detrimental effect of survivors feeling like they cannot tell their stories in court is that they do not receive the inherent benefits of storytelling.[141] Since revealing experiences of violence to fact-finders can have a therapeutic benefit, many clients express a desire to be able to give a full explanation of events. At its best, the legal ***1193** process can be a way for a survivor to find her voice again, which is particularly salient in domestic violence cases.[142] Many clients report that, after years of emotional and psychological abuse, after years in which an intimate partner exerts control over aspects of their lives and outside relationships, and after they have been told no one will believe them, it is important for them to be able to tell someone about the abuse they have suffered, to be believed, and to have these experiences validated through judicial findings. One survivor

expressed, "Just to have someone believe my story literally saved my life."[143] Surveys of victims of sexual assault reveal that they pursued civil remedies primarily because they wanted to be heard and were seeking validation.[144] Protection-order litigants often report that going through the process of filling out forms, relating their experiences to a judge, and getting a court order is very empowering, is worth the trial process,[145] and gives them the strength to leave an abusive relationship.[146]

The therapeutic importance of disclosure has been established both for survivors of domestic violence[147] and for individuals living ***1194** with HIV or AIDS.[148] According to Herman, "[r]emembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims."[149] She posits that recovery requires progressing through three stages: (1) establishing safety; (2) reconstructing the trauma story, which includes telling others this experience; and (3) restoring the connection between survivors and their community.[150] The community response heavily influences the survivor's ability to come to terms with the trauma, as the survivor looks for public acknowledgement of the event and for community action in response to the revelation.[151] For domestic violence survivors, the civil protection order process can be a location for recognition, restoration, and restitution.

The court process is seen as giving survivors of intimate partner violence an opportunity to have their voices heard, but speaking about violence is not without difficulties. Out of a belief that the information is not relevant or because of a desire for privacy, the ***1195** client may not raise HIV-related aspects of violence. Simply recognizing the voices of those who are experiencing domestic violence in the context of HIV and making it possible for these voices to be heard is a crucial first step.

III. Proposed Legal System Advancements that Follow from Understanding the Intersection of Domestic Violence and HIV/AIDS

Until there is an understanding of the interconnectedness of domestic violence and HIV/AIDS, substantive change cannot occur. Part I offers survivors' stories to detail the use of HIV status as a tool of abuse and as a way of "doing power" in intimate partner relationships.[152] Martha Minow describes some of the goals of storytelling in legal scholarship, which include giving "voice to suppressed perspectives," building "a reservoir of alternative understandings through which existing practices can be criticized," and "persuading people to act who currently are in a position to effect change."[153] In Legal Images of Battered Women: Redefining the Issue of Separation, Martha Mahoney tells stories of violence in ordinary women's lives in an effort to "change law and culture simultaneously" by detailing, naming, encouraging reconceptualization in the legal world, and forming responses to separation assault.[154] This Article similarly offers stories from women's lives to explain how HIV/AIDS is often integral to how people experience domestic violence. Illuminating the problem of HIV-related violence can in turn prompt further development of legal response systems.

Part III.A considers more nuanced courtroom options for reporting experiences of violence and protecting HIV-related information. With procedural changes that allow greater courtroom reporting, the resulting understanding of the problem of domestic violence in the context of HIV/AIDS encourages responsive advancements. These developments, discussed in Parts III.B to III.D, include a more complex understanding of domestic violence, substantive changes in the law, judicial remedies that are tailored to experiences of HIV/AIDS-related domestic violence, ***1196** more client-centered lawyering, and response systems that provide a medical component to serve survivors of HIV-related violence.

A. Courtroom Options for Revealing Information

Because the domestic violence response system has not recognized the role of HIV/AIDS in the lives of survivors, it has not considered ways to make courts more accessible to litigants who report the most intimate or stigmatizing details of their lives.[155] Could it be possible for a litigant to choose to reveal HIV status information to a judge without publicizing it to the entire community? This Section proposes systematic and procedural ways to address the current silence, identifies possibilities for protecting litigants' privacy, and discusses potential challenges, risks, and unintended consequences of limiting public access to judicial proceedings.

A systematic change in the ways cases are scheduled could transform the courtroom environment. First, assigning more judges to hear domestic violence cases would ease the volume of each judge's docket. Scheduling fewer cases to a particular courtroom could decrease the audience of litigants and allow judges to give individual litigants more focused attention instead of feeling pressure to dispose of cases and move the docket. Second, clerks could schedule domestic violence cases throughout the day--either individually or to several time slots--to avoid having a mass audience at the beginning of each day. Across jurisdictions, it is common for litigants in all of the domestic violence cases scheduled for a particular day to receive notices to appear at court at the same time.[156] All litigants are present at the start of the day, and litigants and their attorneys may spend the entire day in court as they wait for their cases to be called. Many other branches of courts, including the courts that hear other types of family law cases, schedule cases ***1197** individually.[157] This scheduling recommendation might appear trivial or bureaucratic, but the fact that scheduling does not currently occur is part of the problem that systematically silences certain harmful aspects of litigants' experiences of domestic violence.[158]

Given the social costs of making public one's HIV status, in some instances litigants may wish to bring claims and make allegations while protecting the privacy interests of all involved. Litigants could request that courts limit the disclosure of private information in multiple ways, such as moving to close the courtroom or to hold hearings in chambers in select cases,[159] filing cases using initials or pseudonyms,[160] and sealing portions of records to shield medical ***1198** information,[161] among other options.[162] It is notable that in many non-domestic violence cases alleging discrimination based on HIV status, the petitioner is listed as "John Doe" to protect the complainant's identity, whereas this is not the practice in civil protection order domestic violence cases.[163]

While closing all domestic violence proceedings would run afoul of the First Amendment right of public access to criminal trials,[164] the right of access is a qualified right, and the presumption of openness can be overcome by "an overriding interest based on findings that closure [1] is essential to preserve higher values and [2] is narrowly ***1199** tailored to serve that interest."[165] In cases involving HIV-related domestic violence, anticipated testimony concerning HIV status should heavily influence a court's decision to close proceedings, because HIV- and AIDS-related information is protected by constitutional law, common law, and statutory provisions.[166] As for constitutional law, courts have held that "individuals who are infected with the HIV virus clearly possess a constitutional right to privacy regarding their condition,"[167] and an individual's right to privacy regarding his or her condition can be overcome only if there is a strong countervailing interest.[168] Regarding the first prong, there is a privacy right to HIV-status information,[169] the identities of those with ***1200** HIV or AIDS is typically not a matter of public interest,[170] courts recognize the social stigma surrounding HIV and AIDS and the resulting discrimination,[171] and the state has an interest in protecting individuals who have experienced or are threatened with domestic violence.[172] These reasons strongly weigh in favor of protecting the confidentiality of HIV-related information at a litigant's request. As a point of comparison, the Supreme Court stated that protecting victims of sexual assault from "the trauma and embarrassment of public scrutiny may justify closing certain aspects of a criminal proceeding."[173] A litigant could assert that he or she wishes to retain the confidentiality of this constitutionally protected information, and could move to restrict access to court proceedings or documents, or to ***1201** testify to particularly sensitive aspects of the case in chambers, in a narrowly-tailored manner that would satisfy the second prong.[174]

In addition to the weight that constitutional protections of HIV-related information should have on a court's decision as to whether to close the proceedings, comparing the prospect of having litigants testify about HIV-related aspects of violence to the treatment of cases in other areas of the law is instructive. The public has historically been excluded from juvenile proceedings,[175] adoption cases are generally sealed,[176] and judicial bypass proceedings for minors seeking abortions include confidentiality and anonymity requirements.[177] In addition to this treatment designed to protect minors, judges regularly use their discretion to close or seal cases involving bankruptcy,[178] ***1202** trusts,[179] patents,[180] trade secrets,[181] celebrities,[182] national security interests,[183] business interests,[184] or wealthy litigants.[185] Courts recognize the monetary value of particular types of information, and many judges make allowances to protect business interests, but the same privacy rights and nuanced approaches are not traditionally afforded to domestic violence litigants. A family court judge writes of the challenges of testifying about the personal aspects of family cases: "I simply do not feel that any adult should be expected to bear [sic] his or her soul or suffer embarrassment by speaking about a highly personal and possibly traumatic life experience in front of a group of strangers, including the press."[186] Because litigants have a privacy right in HIV/AIDS status and health information is confidential, and because some of the most

sensitive and deeply personal issues are ***1203** implicated by testimony about AIDS-related violence, exceptions should be made to protect information at a litigant's request.

Asserting privacy interests with the goal of protecting particular information is a complex endeavor, however, because most domestic violence survivors are not represented when they enter the legal system.[187] Consequently, they remain without counsel as they navigate the protective order process. In fact, research has shown that the individuals who are most at risk of high-level violence and possibly most intimidated are highly unlikely to be represented.[188] Pro se litigants often have difficulty filing cases and navigating the court system, and would not be prepared to ask to file under seal, use a pseudonym, make a motion for a closed courtroom, or testify to particularly sensitive aspects of the case in chambers. These examples demonstrate the need for counsel in this civil context, and argue in favor of recognizing a right to counsel under "civil Gideon," ***1204** particularly because the basic human needs of safety and health are at issue.[189] For now, any meaningful option for confidential filing should be accessible to pro se litigants at the initial filing stage.

One way to address this hurdle is for intake counselors and clerks[190] to explain filing options to pro se litigants, including the possibility of confidential filing at the initial filing stage. Forms could offer the option of using a pseudonym or initials, feature a section in which petitioners can indicate that they wish to disclose private medical information without having it become publicly available, and offer the option of motioning the court for a determination about the protection of particular information.

Despite the obvious benefits derived from crafting courtroom options that would protect litigants' privacy, several unintended, negative consequences should not go overlooked. For example, openness of courts is beneficial because it allows the community to ***1205** understand the prevalence of domestic violence and the additional complexities of HIV and AIDS status. The openness of courts was instrumental in achieving greater societal understanding of domestic violence; the ability of survivors to speak out about their experiences and to publicize the commonality of violence against women was an important step in societal change.[191] If all proceedings involving the mention of HIV or AIDS were closed to the public, this would further remove the reality of HIV and AIDS from the mainstream and could encourage continued ignorance about HIV/AIDS.[192] Putting these litigants and their life stories behind closed doors may further silence or shame their experiences and reinforce the status quo. While this concern weighs heavily, it is also disconcerting that litigants struggling with HIV-related violence often do not feel able to testify to these matters. While society expects the courtroom to reveal what is happening in the world, experiences of violence in the context of HIV are currently rarely reported in courtrooms. Granted, these litigants should not be forced to bear the burden of educating the public. In considering cases such as the women's stories in Part I, there could be limited instances, on a case-by-case basis, in which it is appropriate to hold hearings away from the public, seal cases, or use anonymous captions or initials after balancing the litigants' interests. The practice of scheduling cases and assigning fewer cases to a particular docket may effectively resolve privacy concerns for many litigants, and other more nuanced approaches to handling domestic violence cases can be considered.

In addition to undermining awareness, closing courtrooms would limit the public's ability to monitor judges, which is an accountability mechanism vital to litigant safety. Sadly, one can find many instances of judicial mishandling of domestic violence cases, including judges making victim-blaming statements, asking women whether they like to be beaten, and improperly failing to issue orders.[193] These ***1206** examples demonstrate the importance of court monitoring projects,[194] ***1207** which document judges' treatment of litigants and determine whether judges are complying with domestic violence laws, and indicate that an extreme response of closing all domestic violence cases to the public would hamper accountability efforts. Suggestions for reform must always ask whether a particular policy creates more harm to survivors, greater gender subordination, or other problems, and whether it makes the next step of women's liberation harder. Closing all domestic violence courtrooms could have this effect. Therefore, advocates should consider how to avoid this unintended result. For instance, if a case is closed to the public, the court could permit the presence of a court observer who is prohibited from revealing litigants' names or identifying information. This would further the goals of judicial accountability and public awareness of the prevalence and complexities of domestic violence.

Until now, domestic violence courts have not been structured to facilitate the telling of HIV/AIDS-related events, and lack of awareness of the impact of HIV/AIDS in violent relationships has prevented the development of more sophisticated responses. Reforms, such as scheduling cases and making procedural

mechanisms accessible to litigants, could improve access to justice and make domestic violence courtrooms places of dignity and empowerment that encourage abuse survivors to testify fully as they seek the court's protection.

B. An Opportunity for Effective Judicial and Legislative Responses

If domestic violence courts adapt to enable litigants to reveal highly personal, otherwise confidential, information, then the disclosure in court of the HIV-related aspects of violence will allow litigants to receive more effective legal responses. First, when litigants provide details, it enhances their credibility and bridges gaps in the judges' understanding. Second, greater understanding of the complexities of intimate partner violence promotes more responsive laws by allowing lawmakers to see deficiencies in current laws and to create more expansive definitions and new grounds for relief. Third, ***1208** survivors' stories give judges the opportunity to tailor remedies to litigants' actual experiences of violence.

1. Providing Details as a Way of Enhancing Litigants' Credibility and Bridging Gaps in Judges' Understanding

Often, facts about one party's HIV status are integrally related to the physical violence or threats pertinent to the case. When the portions of the incidents involving HIV status are omitted, the context is lost, the harm is concealed, and the court is unaware of the circumstances and extent of the violence.

Some stories simply do not make sense absent the HIV- or AIDS-related facts. The judge may not understand how the event is actionable or what the harm is without this key information. Three examples from Part I illustrate this point. First, when a partner destroys HIV medication,[195] but the petitioner does not testify about the type of medication, the judge may assume the medication is an easily replaceable over-the-counter remedy, such as aspirin, and will not understand its destruction as a violent, health-threatening act. Second, as with the example of the partner who wrote "AIDS bitch" across a mirror,[196] if the word "AIDS" is removed from the telling of this incident, the judge may assume the writing is merely name-calling and will not understand the emotional impact on the petitioner. As a final example of the weight of missing facts, the action of locking someone inside his or her home is always alarming,[197] but it is especially dangerous when the restrained person is experiencing an AIDS-related infection and needs medical attention.

The current practice of telling parts of events and concealing the role of HIV or AIDS in violence may result in broken narratives that undermine the litigant's credibility and leave the judge wondering what is missing. Judges naturally deny requests for protection orders when the alleged incident does not appear to be actionable or make sense. If the testimony did not omit significant portions of stories, more petitioners who are legally entitled to protection orders might be awarded them.

A petitioner's testimony about her individual experiences with HIV-related violence helps fill in details, provides important background information, and gives meaning to the violence. Individuals' stories can persuade legal decision-makers by generating ***1209** comprehension, evoking compassion, and "creating a bridge across gaps in experience and thereby elicit empathic understanding."[198] Not every judge and lawmaker can be expected to have a personal life experience involving the intersection of domestic violence and HIV or AIDS,[199] but hearing others' stories can shed light on an issue and personalize and humanize the problem.

2. Individuals' Stories as an Impetus for More Responsive Laws

HIV/AIDS creates new circumstances for the laws of domestic violence. Because the stories of victims of HIV-related domestic violence are absent from the courtroom and are not spoken to the public, these stories cannot push the boundaries of current laws and prompt change. The voices of those experiencing the combined problems of domestic violence and HIV/AIDS have historically been unrepresented in lawmaking and in the judicial and legislative process,[200] and bringing to the forefront examples of these experiences is the first step in accomplishing legal and systemic reforms that will be more responsive to the survivors' needs.[201] ***1210** Individuals' stories will prompt lawmakers to recognize deficiencies in current laws, challenge oversimplified definitions of domestic violence, create broader definitions that encompass more survivors' experiences of violence, and suggest new bases for seeking a court's protection.

a. Identifying Deficiencies in the Law

Through hearing about experiences of violence, the listener can recognize deficiencies in current substantive laws and legal practices. Bringing these stories into courtrooms and to the attention of judges confronts decision-makers with individuals' immediate personal experiences and "forces legal decision-makers to acknowledge the pain that results from the legal system's inadequate response to human problems."[202] Violence in a home typically remains unseen ***1211** and comes into view only when revealed to an advocate or judge. Judges then play a role in defining domestic violence by including details about it in their opinions.[203] When litigants more fully testify to their experiences, these more complete litigant narratives permit more nuanced and developed judicial narratives, which promote legal reform. Zanita Fenton instructs judges to further society's understanding of domestic violence by including a full description of facts specific to each case in court opinions and writing a complete story of the violence.[204] She believes that judicial storytelling is a predicate to new legislation and is central to effectuating change.[205] Fenton writes, "The courts play a crucial role in demonstrating injustices in the law's application and its inadequacies, thereby making it possible for the law to approximate more closely true justice. Omission of the full story, the full set of facts . . . erases the voices of human beings."[206] Gaining greater understanding of complex social and legal issues based on individuals' stories should cause lawmakers and legal decision-makers to craft more appropriate legal responses, recognize how these newly learned experiences could be incorporated into legal reform, and even work toward the implementation of law reform.[207]

The stories of violence in the context of HIV reveal experiences that extend beyond situations which lawmakers have previously considered to legally define domestic violence. These litigants currently find themselves "invisible before the law,"[208] but their stories can challenge the shortcomings in conventional ***1212** understandings of domestic violence. The recognition of these complex connected problems--of the significance of HIV/AIDS in domestic violence--creates opportunities to envision what legal response systems and courts could do differently to better respond to these litigants. Through the lens of HIV/AIDS in domestic violence, lawmakers can rethink the current statutory definitions of domestic violence and grounds for seeking protection orders.

b. Challenges to an Oversimplified Legal Understanding of Domestic Violence and the Need for an Expansion of Grounds for Relief

Understanding the many ways in which an abusive partner can exercise power and control, along with the complexities of HIV-related domestic violence, challenges the current oversimplified legal definitions of domestic violence and encourages both more sophisticated, nuanced definitions and expanded grounds of relief. Statutory definitions could be expanded to address a wider range of occurrences of domestic violence. Protection order statutes typically predicate the award of an order on proof that the opposing party committed a qualifying criminal offense.[209] The criminal offense requirement, in essence, becomes the legal definition of domestic violence in a state, because a petitioner must allege a recognized criminal offense to gain relief. This is a much more restricted definition for domestic violence than the commonly accepted definition: a pattern of behavior in a relationship that is used to gain or maintain power and control over an intimate partner.[210] The law ***1213** typically equates domestic violence with physical assault[211]--the most straightforward and common ground for seeking a protection order. It is easy to recognize a punch, kick, or stabbing as a criminal act, but physical abuse only encompasses part of the experience of domestic violence.[212] Because emotional abuse, economic abuse, and other ways of controlling an intimate partner's life are not criminal offenses, these actions do not form the basis for the legal recourse of a protection order in most states.[213]

***1214** The current statutory definitions oversimplify the problem of domestic violence and do not include the many ways in which abusive partners exercise power and control in relationships. Definitions of abuse could include a wider range of intimidation, emotional abuse, and threats of social harm, along with the currently recognized physical assault and battery. The civil protection order domestic violence remedy could be retooled to respond to more survivors' actual experiences of violence without criminalizing all behaviors that constitute emotional, economic, and psychological abuse. While current laws suppress certain stories and relevant contexts, progress in recognizing HIV-related intimate partner violence can broaden and transform the legal system's understanding of the battering relationship.

The limitations of the current statutory definitions can be realized by considering some of the ways HIV/AIDS is used in violence. For example, threatening to reveal a person's HIV status as a way to keep someone in a relationship is not a recognizable criminal offense, but it is a highly effective way to exert control over an intimate partner. Missouri's inclusion of "coercion" in its definition of abuse is an example of a progressive legal development consistent with understanding domestic violence as a way to gain and maintain power and control in a relationship.[214] When state civil protection order statutes recognize stalking or harassment as actionable, they often require the petitioner to be in imminent fear of bodily harm,[215] but the emotional distress inflicted by the perpetrator could be sufficient to prompt legal remedy. Harassment could encompass actions producing social harm. Insults about HIV/AIDS status are hurtful to victims and could be categorized as emotionally or psychologically abusive or as harassment but generally do not fit into ***1215** recognized categories of grounds for a protection order. Words that might not ordinarily fit within a definition of harassment, if they are about HIV status, could be recognized within existing harassment statutes, and other state statutes could expand to encompass HIV-related cruelty.

Exploring the expansion of grounds for obtaining protection orders through the lens of the use of HIV/AIDS status in domestic violence benefits survivors of intimate partner violence in general, regardless of whether they are affected by HIV-related violence.[216] For example, medical interference could become a new ground for receiving a protection order. Frequently, partners will interfere with the medical care of HIV-positive abuse victims by preventing them from attending health care appointments[217] or by taking or destroying their medication.[218] Medical interference, while it is especially dangerous to an HIV-positive individual following a strict medical regimen, is generally harmful to any person. People with health conditions other than HIV/AIDS would also benefit from legal recognition of medical interference or endangerment in the HIV context.

Hearing stories in court and recognizing the events as part of battering--and simultaneously seeing the limits of the law--might compel legal authorities to expand statutory definitions. This should lead to a general consideration of the multiple contexts in which domestic violence occurs, push out the boundaries of current stock stories, and induce the legal system to address domestic violence more comprehensively.[219]

***1216** 3. Tailored Remedies in Response to Litigants' Actual Experiences of Violence

Domestic violence survivors come to court seeking assistance. The best help can be delivered when a survivor is able to explain accurately what has happened and why. After a judge hears the survivor's story, the judge can recognize the influence of HIV in her life and in the domestic violence she has experienced and can craft an appropriate remedy. Without understanding the nature of the violence, the judge is unable to award relief that is tailored to the litigant's actual experience, and the court remedy may not fully serve the litigant's goals or be a just result.

To facilitate better-tailored relief, judicial training[220] should raise awareness of the use of HIV or AIDS status in domestic violence. Educational sessions should prepare judges to think beyond a ***1217** simplified, prototypical definition of domestic violence. These sessions should encourage judges to recognize other complicating factors and consider how these factors impact litigants and vary their needs for relief. Judicial training should explore a variety of procedural options for protecting litigants' privacy, increase judges' knowledge of community resources for treating HIV/AIDS, and recommend relief that specifically addresses HIV-related aspects of violence.

Legal remedies are essential to domestic violence interventions, but current remedies too often address only a limited, over-simplified understanding of violence in relationships. Litigants' testimony may motivate decision-makers to develop remedies that better respond to the various contexts in which the dynamics of power and control occur. For example, it may be appropriate for judges to offer referrals to medical clinics and to community resources. Domestic violence statutes in many jurisdictions invite judges to develop relief that suits the needs of the litigants before them.[221] For relief targeted at medical interference, a judge may order the respondent not to interfere with the petitioner's medical treatment. These orders could include not taking, tampering with, or destroying her medication or obstructing her ability to attend medical appointments or receive health care workers into the home. If the abusive partner has threatened to publicize the victim's HIV status, the judge could enter a remedy directly addressing this scenario. Once a survivor of intimate partner

violence files a petition for a protection order, which necessarily includes allegations of abusive actions, there is the possibility that the respondent will take retaliatory actions. Thus, a judicial order might be necessary to limit the respondent's socially harmful speech or other actions.[222] Such an order could make it possible for more survivors to seek relief. Penalties for violating a ***1218** protection order include jail sentences and fines, and explicitly tailored relief in a protection order compels the respondent to comply or risk being found in contempt. In sum, when a survivor is able to testify to what has actually happened, a judge can award remedies that respond to the person's particular needs and actual experience of violence.

Civil protection orders are designed to deal with harm that happens in the home, where people often do not have access to protection. We now know that these orders can be effective in addressing the violence from which people need protection.[223] The harms of HIV-related violence deserve and require protection; they are serious enough to trigger civil protection order actions or justify remedial relief.

C. Client-Centered Representation of Survivors of HIV-Related Domestic Violence

Awareness of the possibility of HIV-related domestic violence needs to be raised among lawyers and safety advocates so that they can provide a higher quality of client-centered representation. Only a small number of attorneys are trained to represent domestic violence survivors,[224] and more lawyers need to receive careful training in the dynamics of abuse, relevant law, safety planning, lethality assessment, the complexity of domestic violence, and multiple barriers that survivors face. Domestic violence survivors who are represented by attorneys are significantly more likely to be awarded civil protection orders than those who are unrepresented, and their orders contain more effective and complete relief.[225] For orders to accurately address a survivor's situation, the lawyer needs to listen carefully to the client, attempt to understand the totality of the survivor's unique experience, and be open to learning her individual legal and nonlegal goals and needs.[226] But since the role that HIV or AIDS can play in ***1219** domestic violence is not widely recognized, lawyers may not unearth or identify this intersection.[227] The lawyer may essentially have a formula or pre-constructed domestic violence story into which he or she assumes clients fit. Clients' cases are often classified as a "case-type," and lawyers may not inquire beyond their basic understanding of the prototypical domestic violence case. By identifying a familiar legal problem, the lawyer may selectively hear facts that fit within the universalized legal narrative, thereby displacing or silencing a client's story. Lawyers need to be attuned to the possibility of a more complex background than a "stock story," including the possibility of HIV/AIDS-related domestic violence. Being aware of this possibility allows lawyers to understand the nature and depth of the violence and harm to the client, and it helps lawyers create procedural and substantive options based on their clients' actual experiences.[228]

***1220** Lawyers help clients navigate the court system, stand with clients as they reveal painful stories and seek help, and work with clients to achieve their goals. Lawyers should approach representation with the understanding that this is the client's life and client's case, and embrace a client-centered model of representation.[229] Client-centered counseling and decision-making requires lawyers to involve clients while considering and creating options, and ultimately allows clients to make decisions themselves, including decisions about what to argue and who will testify.[230] As described in Part II, the presence of HIV or AIDS in either partner will likely affect case strategies, from the details included in allegations to questions such as whether to take a case to trial, how to proceed in court, and what relief to seek. The client is her own best expert on her life, and the client's involvement in decisions about her legal case is paramount. The client has to be comfortable with the story that is told about her at trial,[231] because the legal case makes outward representations about the client,[232] and the client is the one who lives with the consequences of the decisions made. Clients often choose to provide only some of ***1221** the facts of an incident,[233] leaving out those facts that involve threats regarding HIV-status, medication, or sexual assault and fear of contracting HIV, in favor of sometimes weaker or less compelling allegations. In not volunteering the type of information that a client seeks to protect, the lawyer is being client-centered and sensitive to the idea of dealing with someone else's life story. By better understanding the client's experiences and life, the lawyer can have greater insight into what is at stake for the client.

Without knowledge of the intersection between HIV/AIDS and domestic violence, the lawyer will not counsel the client about HIV resources. However, with the knowledge, the lawyer can see the advocate's role as

including provision of information about the risk of being infected with HIV. Safety planning should incorporate conversations about complications from HIV-related violence and safety precautions that are advisable because of the violence.[234] Focusing on clients' legal and nonlegal barriers and goals can instill in lawyers the habit of connecting clients with community resources to the extent the clients wish to use the assistance.

D. Multidisciplinary Solutions: The Necessity of Medical and Legal Interventions

The complexities and interrelation of HIV and domestic violence demand critical examination of the structures in place for addressing domestic violence and the creation of innovative and multidisciplinary approaches.[235] Part of the coordinated community response to domestic violence should be the provision of medical interventions. Such care is essential to serving the needs of abuse survivors more comprehensively.

Services for abuse survivors are typically dispersed throughout a city, and a survivor must exert tremendous energy in seeking safety resources, police assistance, legal representation, courthouse ***1222** remedies, emotional support, and medical care.[236] Restriction of activities in violent relationships, isolation, the emergency nature of the need for assistance, and financial, transportation, and logistical constraints are likely to reduce an abused woman's ability to access multiple domestic violence and community resources. Realizing these barriers, some cities have created centralized victim service centers that house criminal and civil justice systems' advocates in one location.

Centers that serve as examples of coordinated responses include the District of Columbia's Domestic Violence Intake Center,[237] which opened its courthouse location in 1996 and its satellite hospital center in 2002, and San Diego's Family Justice Center, which opened in 2002.[238] The Washington, D.C., intake center was designed to serve as an entry point for domestic violence complainants to "provide victims with a 'one-stop shopping' intake center that provides comprehensive assistance with the full range of intimate violence litigation and related social services."[239] There, safety counselors make referrals for emergency housing, support groups, and other community services; civil intake counselors explain the court process, help victims draft and file petitions for protection orders, and give legal referrals; a police officer can make a police report; a representative from the office of paternity and child support can begin a permanent child support case; and a victim/witness advocate from the prosecutor's office is available.[240] The San Diego model, while similar, also ***1223** engages religious and business leaders.[241] Locating multiple services under one roof was a revolutionary breakthrough in addressing domestic violence, and recent government grants are funding new coordinated centers in cities across the United States.[242] Further development of such sites should be encouraged, with an emphasis on an individual survivor's situation, life circumstances, and vulnerabilities.

Traditionally, domestic abuse intervention programs and HIV/AIDS prevention and treatment programs have operated independently of each other, addressing these epidemics as two separate public health issues.[243] To effectively intervene in and ultimately prevent domestic violence, services for persons with HIV/AIDS should be factored into a comprehensive coordinated community response to domestic violence. With the proliferation of centralized domestic violence response sites, these already-existing centers provide a locus for addressing HIV-related violence. The community response needs to be nuanced, individualized, and open to assisting clients with a range of problems, including the intersection ***1224** of domestic violence and HIV/AIDS.[244] Legal and medical fields' responses should be complementary. Domestic violence service providers can counsel abuse survivors about HIV risk;[245] doctors, nurses, and medical personnel are in a unique position to recognize domestic violence;[246] and both disciplines should link to community resources. A survivor-centered approach requires looking at additional disciplines beyond the justice system to offer options to meet a range of survivors' needs.

The model of co-located services and coordinated community efforts can be expanded beyond the legal realm to increase survivors' access to medical care and improve their mental and physical well-being. Domestic violence survivors seeking services have often experienced high-level violence, are injured, and need urgent legal and medical responses. Some centers currently have a forensic medical component that collects evidence and documents abuse for use in prosecution, and also refers patients to hospitals for treatment.[247] A medical presence that provides emergency treatment, clinical care, and health counseling and advice would significantly

complement current legal and advocacy services. Coordinating and co-locating services is important because "[l]egal services that are not integrated with other vital services to HIV-infected women--such as primary medical care, mental health, substance use treatment, . . . [and] emergency financial assistance . . .--will at best only partially ***1225** address clients' needs."[248] The multiple possibilities for coordinating medical and legal interventions include creating advocacy centers at health clinics and hospitals, placing health care professionals in intake centers and forming patient treatment areas there, and making public health and medical professionals part of any coordinated response to domestic violence.[249] In addition, criminal and civil justice system ***1226** advocates who are already part of a centralized site should be educated in how domestic violence increases the risk of HIV infection, and they should become familiar with HIV/AIDS resources in their region.[250] Support groups, community outreach efforts, and public awareness campaigns should reflect the complexities of domestic violence, including its intersection with HIV/AIDS.

The medical field has largely failed to screen for domestic violence and to recognize the health care implications of abuse even though research shows that patients will disclose this information to doctors when asked.[251] In a recent nationwide study of approximately 5000 women, only seven percent said that a health professional had ever asked them about domestic or family violence.[252] Contrary to clinical guidelines,[253] doctors have confirmed that they do not ask ***1227** about domestic violence because of time constraints, lack of training, their own discomfort, fear that they would "open a Pandora's box,"[254] and the absence of community services that would help patients experiencing family violence. Doctors also reported feeling unequipped to respond to patients who volunteer information about violence in the home.[255] Medical professionals may be the first and only outsiders who have the opportunity to offer interventions in domestic violence and to see the impact of violence on the family, and an active response by these professionals is critical.[256] Given the high rates of HIV transmission among abuse victims and their increased problems adhering to medicine regimens,[257] the medical sector cannot ignore the health care implications of domestic violence and the ways ***1228** in which domestic violence complicates the medical response to HIV.[258]

In light of the health issues at stake, legal responses must not continue without attention to medical interventions. Providing legal and health remedies in isolation from each other fails to effectively intervene in the domestic violence situation and address health needs.[259] Medical treatment alone does not provide for someone's safety from intimate partner abuse, whereas a legal order could protect against physical and emotional abuse, threatening speech, and interference with health care. Legal solutions alone clearly cannot provide the medicine regimen and clinical care that are vital to treating HIV. Because severe stress speeds the time between HIV infection and the development of AIDS, legal remedies, advocacy support, and comprehensive services to assist victims of abuse could positively contribute to a survivor's health.[260] Even today, an alarmingly high percentage of infected individuals are considered "late testers," meaning that they learn they have AIDS within a year of the HIV diagnosis and suffer greater medical problems.[261] The legal and medical fields need to work together in a multidisciplinary response, because timely interventions[262] are essential to an effective response to domestic violence in the context of HIV/AIDS.

***1229 Conclusion**

HIV or AIDS status can be related to domestic violence in multiple ways, including violence that escalates following partner notification of HIV status, interference with medical treatment, sexual assault resulting in infection, and threats to reveal status. The current lack of recognition of the relationship between HIV/AIDS and domestic violence impedes survivors' receipt of effective assistance. Conversely, awareness of the intersection sheds light on ways the legal system could better respond to HIV/AIDS-related violence. Adjustments in the court process through which survivors reveal the issues that implicate the most intimate and personal aspects of their lives could result in more survivors telling their stories in court. One solution could be scheduling domestic violence cases throughout the day, as opposed to requiring all litigants to appear at the same time. If survivors were able to describe the violence fully and accurately, judges and legislators could understand this complexity, award relief that responds to the actual domestic violence experience, and expand laws based on this deeper understanding of domestic violence. Additionally, centralized intake centers could include medical interventions to more holistically serve victims of violence. If lawyers, judges, and legislators would look at the multiple complexities some survivors face and reject an oversimplified understanding of domestic violence, all survivors of domestic violence would benefit. The voices of those who suffer at the

intersection of HIV/AIDS and domestic violence have not been recognized. Their stories demand multidisciplinary responses and new ways to better hear, serve, and work with these survivors.

Footnotes

aa1 Practitioner-in-Residence and Director, Domestic Violence Clinic, American University, Washington College of Law. LL.M., Georgetown University Law Center; J.D., Harvard Law School; B.A., University of Kansas. I am grateful to Deborah Epstein, Ann Shalleck, Laurie Kohn, Adrienne Lockie, and Lea Johnston for their insightful comments to earlier drafts. I wish to thank Marie-Helene Prinz, Jessica Burt, Dari Yudkoff, and Valentine Khaminwa for their invaluable research assistance. I am thankful for the encouragement of Jane P. Stoever, Henry Stoever, Anneliese Stoever, and David Min, and for their commitment to hearing and valuing each person's voice.

1 In this Article, I use the terms "victim" and "survivor" to refer to individuals who have experienced domestic violence. I use these terms interchangeably because I see my clients as incredibly smart, strong people who have survived trauma. I also see that the violence is central in their lives, particularly at the point at which I am working with them. The domestic violence aspect of a person's experience does not define his or her entire identity, and the choice of terms is a challenging question. There has been much discussion among advocates about what to call someone who has experienced abuse in an intimate relationship, and the answer to this question is not settled. See, e.g., Nancy K. D. Lemon, Access to Justice: Can Domestic Violence Courts Better Address the Needs of Non-English Speaking Victims of Domestic Violence?, 21 Berkeley J. Gender L. & Just. 38, 38 n.2 (2006) (using the term "victim" rather than "survivor" because individuals "who are requesting court intervention are likely to be in the initial stages of stopping the violence, and therefore may think of themselves as 'victims,' rather than 'survivors"'); Martha R. Mahoney, Exit: Power and the Idea of Leaving in Love, Work, and the Confirmation Hearings, 65 S. Cal. L. Rev. 1283, 1311 n.115 (1992) (explaining that, from a feminist perspective, the label "victim" has been replaced with the term "survivor").
I sometimes refer to clients and individuals who have experienced abuse as female and to perpetrators of abuse as male. The terms are not meant to discount the reality that men are also victims of domestic violence. Rather, the terms reflect data showing that women experience domestic abuse more frequently than men. In the Domestic Violence Clinic that I direct, the vast majority of clients are women who have been abused by men, which is consistent with the general statistic that approximately eighty-five percent of victims of domestic violence are female. Bureau of Justice Statistics, U.S. Dep't of Justice, Family Violence Statistics 1 (2005) (reporting that eighty-four percent of spousal abuse victims are female, and among non-married couples, females experience abuse in eighty-six percent of battering relationships). This tendency of gender identification in my use of pronouns is also not meant to ignore the existence of domestic violence in same-sex relationships.

2 Domestic violence is commonly understood to include a range of actions to gain and maintain power and control over an intimate partner. Domestic violence may include: sexual assault; physical abuse; emotional and psychological abuse; economic abuse; threats; and intimidating, manipulating, hurtful, and controlling behaviors. See, e.g., Martha R. Mahoney, Legal Images of Battered Women: Redefining the Issue of Separation, 90 Mich. L. Rev. 1, 93 (1991) (defining domestic violence as power and control marked by violence and coercion).

3 In this Article, I interchange the terms HIV/AIDS, HIV, and AIDS, referring to the same general condition and its role in domestic violence. When the stage of infection is relevant, either HIV or AIDS is used.

4 I teach Family Law and Domestic Violence Law and direct the Domestic Violence Clinic at American University, Washington College of Law. The Clinic addresses clients' legal and nonlegal needs while representing clients in civil protection order and immigration cases. Before engaging in this type of representation, I never anticipated how HIV/AIDS could play a role in intimate partner violence and the power and control dynamics in an abusive relationship. As I represented women who had been abused by intimate partners in civil protection order cases in the District of Columbia, I quickly saw that this intersection was the reality of my clients' lives. The students that I supervise also seem most troubled by these cases, these clients' personal struggles, and the inadequacies of current legal response systems.

[5] Many authors set forth a case example or client narrative to frame an Article. I have chosen to intersperse multiple examples and voices throughout this Article to convey how frequently HIV/AIDS plays a role in intimate partner violence and to show a variety of ways in which this occurs. As I describe my clients' experiences, I simply indicate that this is a client's experience; I do not use names or identifying details, and I do not provide further citation. Some of the studies that I cite attribute quotations to named individuals, but I do not repeat their names here. None of the client experiences or other documented revelations contains fabricated details; my purpose is to demonstrate the reality of the intersection of domestic violence and HIV/AIDS in these abuse survivors' lives. These real-world events are dramatic enough on their own.
Ethical considerations abound in telling someone else's story. See, e.g., Binny Miller, Telling Stories About Cases and Clients: The Ethics of Narrative, 14 Geo. J. Legal Ethics 1, 30-31 (2000) (analyzing the ethical issues involved in telling clients' stories). Relevant to this Article, Miller concludes that macrostudies pose fewer ethical dilemmas than a detailed client narrative. Id. Additional risks include insensitivity, mis-representation, and the appropriation of another's pain. See Colleen Sheppard & Sarah Westphal, Narratives, Law and the Relational Context: Exploring Stories of Violence in Young Women's Lives, 15 Wis. Women's L.J. 335, 346 (2000) (raising concerns about assuming authority to write about others' experiences); see also Mari Matsuda, Affirmative Action and Legal Knowledge: Planting Seeds in Plowed-Up Ground, 11 Harv. Women's L.J. 1, 13 (1988) ("[T]he voice-once-removed is sometimes the only one available to tell that story in the universities.").

[6] See Mahoney, supra note 2, at 93.

[7] Most attention to the spread of HIV focuses on Africa, the continent with the highest HIV rates in the world. Scholarship has focused on how gender inequality, women's lack of control over their own sexuality, and cultural practices increase women's vulnerability to AIDS in Africa. Certain practices--such as polygamy, bride price, widow inheritance, sexual cleansing, dry sex, and the myth that having sex with a virgin will cure the disease--have contributed to the spread of HIV/AIDS in Africa. See Corinda Kelly, Study Note, Conspiring to Kill: Gender-Biased Legislation, Culture, and AIDS in Sub-Saharan Africa, 6 J.L. & Fam. Stud. 439, 441-43 (2004).

[8] Antonia C. Novello & Lydia E. Soto-Torres, Women and Hidden Epidemics: HIV/AIDS and Domestic Violence, Female Patient, Jan. 1992, at 17, 17.

[9] This term of art is commonly used by women's advocates in Africa to describe the intersection of domestic violence and AIDS, and the term is increasingly being used on other continents. Cf. Patrick Letellier, Twin Epidemics: Domestic Violence and HIV Infection Among Gay and Bisexual Men, in Violence in Gay and Lesbian Domestic Partnerships 69, 69 (Claire M. Renzetti & Charles Harvey Miley eds., 1996) (addressing the "twin epidemics" in the context of male gay and bisexual relationships in the United States); Press Release, The Global Coal. on Women and AIDS, Concerted Action Required to Address the Twin Epidemics of Violence Against Women and AIDS (Nov. 25, 2005), available at http://data.unaids.org/GCWA/gcwa_ps_%2025nov2005._en.pdf (calling on all governments to address the "twin epidemics" as they affect women).

[10] See Symposium, Queer Law 2000: Current Issues in Lesbian, Gay, Bisexual, and Transgender Law, 26 N.Y.U. Rev. L. & Soc. Change 137, 152 (2000) ("[P]eople who are going around and talking about safe sex should be thinking about the ways in which domestic violence affects transmission. People who are doing domestic violence work should be assessing the ways in which HIV status is used as a tool of abuse.").

[11] The first cases of what is now known as AIDS were reported in the United States in June 1981. Ctrs. for Disease Control & Prevention, HIV and AIDS--United States, 1981-2000, 50 Morbidity & Mortality Wkly. Rep. 429, 430 (2001).

[12] By May 1983, the Centers for Disease Control and Prevention ("CDC") had received reports of 1,366 AIDS cases, seventy-one percent of which were among gay men. Jeffrey Selbin & Mark Del Monte, A Waiting Room of Their Own: The Family Care Network as a Model for Providing Gender-Specific Legal Services to Women with HIV, 5 Duke J. Gender L. & Pol'y 103, 105 (1998); see also Jose Antonio Vargas, Once a Pioneer in AIDS Battle, District Is Now Fighting Blind, Wash. Post, Mar. 26, 2006, at A1 (explaining that, in America, AIDS initially affected homosexual men having unprotected sex and intravenous drug users sharing needles).

[13] In 1985, women comprised just over seven percent of AIDS cases. U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Responding to the Needs of Women with HIV: Title I and Title II Ryan White CARE Act 17 (1997).

[14] Because homosexual men were affected at the highest rates, health and legal services developed in response to men's health and legal needs. See Selbin & Del Monte, supra note 12, at 117 (explaining that early HIV services were not designed with women's needs in mind); Julian Bond, Black America Must Confront AIDS, Wash. Post, Aug. 14, 2006, at A13 (discussing how media images portrayed AIDS as a disease that only affected gay white men).

[15] AIDS was also transmitted through blood transfusions and spread among heterosexual couples, teenagers, the elderly, and across all races, classes, and sexual orientations.

[16] See Hortensia Amaro, Love, Sex, and Power: Considering Women's Realities in HIV Prevention, 50 Am. Psychologist 437, 437 (1995) (exploring the public perception that women were not affected by AIDS).

[17] Id.

[18] See Selbin & Del Monte, supra note 12, at 132 (discussing how HIV-positive women have been underserved by the health care system); Susan L. Waysdorf, Families in the AIDS Crisis: Access, Equality, Empowerment, and the Role of Kinship Caregivers, 3 Tex. J. Women & L. 145, 149 n.7 (1994) ("Women with HIV infection and AIDS generally have been excluded from clinical drug trials, have been left undiagnosed, are generally poorer, have no health insurance, and have no point of entry into the health care system necessary to obtain effective treatment of AIDS.") (citation omitted).

[19] Worldwide, nearly forty million people are HIV-positive, and twenty-five million have died as a result. Bond, supra note 14 (citing global statistics as of 2006). AIDS is a global epidemic, and HIV prevention and HIV/AIDS treatment need to continue both abroad and in the United States. See Gardiner Harris, Higher Figures Are Expected for Infection of AIDS Virus, N.Y. Times, Dec. 2, 2007, at 32 (reporting on President Bush's nineteen percent decrease in funding for AIDS prevention in the United States, in inflation-adjusted terms, from 2002 to 2007).

[20] The CDC estimates that in the United States, 1,039,000 to 1,185,000 persons are living with HIV. These statistics were captured in 2003. Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., HIV and AIDS in the United States: A Picture of Today's Epidemic, http://www.cdc.gov/hiv/topics/surveillance/united_states.htm (last visited Apr. 8, 2009).
The CDC has found that the United States substantially underestimated the number of people who contract HIV each year. New estimates show that 56,300 people contracted HIV in 2006, rather than 40,000, as previously reported. Lawrence K. Altman, H.I.V. Study Finds Rate 40% Higher than Estimated, N.Y. Times, Aug. 3, 2008, at A1 (citing H. Irene Hall et al., Estimation of HIV Incidence in the United States, 300 J. Am. Med. Ass'n 520 (2008)). The CDC now recognizes that previous statistics also underreported the number of people in the United States who are infected with AIDS each year. Harris, supra note 19.

[21] This approximation was made regarding the year 2006. Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., Basic Statistics, http://www.cdc.govhiv/topics/surveillance/basic.htm (last visited Apr. 8, 2009).

[22] Susan Levine, Study Calls HIV in D.C. a "Modern Epidemic," Wash. Post, Nov. 26, 2007, at A1.

[23] Levine, supra note 22. The annual rate for new AIDS cases is ten times higher in Washington, D.C., than the national average. Id.; All Things Considered: Washington, D.C., Battles AIDS Health Crisis (NPR radio broadcast Feb. 7, 2006) (transcript on file with the North Carolina Law Review).

[24] See Amaro, supra note 16, at 438; Andrea Carlson Gielen et al., HIV/AIDS and Intimate Partner Violence:

Intersecting Women's Health Issues in the United States, 8 Trauma, Violence & Abuse 178, 179 (2007) (concluding that the most common source of infection for women is through heterosexual contact, which accounted for seventy-eight percent of new infections in women in 2004).
Because of anatomical differences, women are much more susceptible to acquiring HIV heterosexually than men. Numerous studies confirm that in heterosexual transmission, male-to-female transmission of HIV is dramatically more probable than female-to-male transmission. Amaro, supra note 16, at 438; see also Catherine F. Klein & Leslye E. Orloff, Providing Legal Protection for Battered Women: An Analysis of State Statutes and Case Law, 21 Hofstra L. Rev. 801, 922 n.765 (1993) ("Ninety-eight percent of heterosexual transmission of the HIV virus is from men to women and only two percent of transmission is from women to men.") (citation omitted); Novello & Soto-Torres, supra note 8, at 18 (citing the Padian study, which determined that HIV is approximately twelve times more likely to be transmitted from male to female than from female to male).

25 See, e.g., Selbin & Del Monte, supra note 12, at 114 (noting that AIDS is the third most common cause of death for women in the United States ages twenty-five to forty-four, but it is the leading cause of death for African American women in this age bracket); Darryl Fears, U.S. HIV Cases Soaring Among Black Women; Social Factors Make Group Vulnerable, Wash. Post, Feb. 7, 2005, at A1; All Things Considered: Washington, D.C., Battles AIDS Health Crisis, supra note 23 (stating that, in the District of Columbia, black or Latina women account for eighty-five percent of all new AIDS cases).

26 Fears, supra note 25. According to the Centers for Disease Control and Prevention, in 2003, "the rate of new AIDS cases for black women was 20 times that of white women and five times greater than the infection rate for Latinas." Id. These statistics are striking, and the reasons for this demographic trend have been examined elsewhere. Id. This Article's examination of the overlap of domestic violence and HIV/AIDS and the recommendations in Part III aim to improve the legal response systems for all survivors of HIV-related violence.

27 See Selbin & Del Monte, supra note 12, at 114 ("AIDS in the United States is increasingly a disease of low-income women of color, disproportionately affecting some of the most politically, socially, and economically disempowered and marginalized members of society. Although they share many legal and other needs with low-income HIV-infected people generally, women living with HIV also face many distinct, gender-specific barriers to having their needs met.").
A range of social factors influence the rates of HIV, including living conditions and socioeconomic status. It is essential to consider these factors in devising appropriate responses. For example, numerous studies on women's socioeconomic status and its influence on women's experiences of abuse and HIV/AIDS risk show that power imbalances between the sexes limit women's choices of safer sex, and that ethnic and sexual gender norms adversely impact women's condom use. See Yolanda R. Davila & Margaret H. Brackley, Mexican and Mexican American Women in a Battered Women's Shelter: Barriers to Condom Negotiation for HIV/AIDS Prevention, 20 Issues in Mental Health Nursing 333, 335-43 (1999) (finding that condom use may be negatively influenced by ethnic characteristics, cultural values, and the presence of abuse in relationships).

28 This Article does not suggest that those with HIV or AIDS are more likely to commit intimate partner violence. High levels of domestic violence exist in all populations, and being HIV-positive does not make one more likely to be abusive.

29 See infra Part I.B.

30 See Andrea Carlson Gielen, Karen A. McDonnell & Patricia J. O'Campo, Intimate Partner Violence, HIV Status, and Sexual Risk Reduction, 6 AIDS & Behav. 107, 107 (2002); Bronwen Lichtenstein, Domestic Violence, Sexual Ownership, and HIV Risk in Women in the American Deep South, 60 Soc. Sci. & Med. 701, 706 (2005) (reporting on a study consisting of focus groups and narrative interviews in which women discussed how "HIV risk occurred in the process of becoming a 'captive body,' that is, one that was beaten, raped, confined, deprived, or isolated by men who viewed women in terms of use value through sexual ownership"); see also Laura M. Bogart et al., The Association of Partner Abuse with Risky Sexual Behaviors Among Women and Men with HIV/AIDS, 9 AIDS & Behav. 325, 325 (2005) (finding that intimate partner violence is associated with an increased risk of HIV transmission and stating, "[i]ndividuals who have been abused by their partners have a higher likelihood of contracting sexually transmitted diseases, and report less frequent condom use and greater engagement in sex work") (citations omitted).

[31] See Sally Zierler et al., Violence Victimization After HIV Infection in a US Probability Sample of Adult Patients in Primary Care, 90 Am. J. Pub. Health 208, 211 (2000). Multiple clients' explanations of violence and a growing body of public health studies confirm this link. Id. A study of almost 3,000 HIV-positive adults found that 20.5% of women, 11.5% of homosexual men, and 7.5% of heterosexual men reported physical harm by a partner or significant other, and approximately half reported that their HIV status was the cause of the violence. Id.

[32] Kristin L. Dunkle et al., Gender-Based Violence, Relationship Power, and Risk of HIV Infection in Women Attending Antenatal Clinics in South Africa, 363 Lancet 1415, 1419 (2004). Multiple studies examine these "overlapping epidemics" and have established the connection between HIV risk and domestic violence. Vermont Medical Society, Domestic Violence Stats & Facts, http://www.vtmd.org/Domestic%20Violence/Stats&facts.html#_edn20 (last visited Apr. 8, 2009); see, e.g., Mardge Cohen et al., Domestic Violence and Childhood Sexual Abuse in HIV-Infected Women and Women at Risk for HIV, 90 Am. J. Pub. Health 560, 560 (2000) ("Women at highest risk for domestic violence are demographically similar to women at risk for HIV infection."); Andrea Carlson Gielen et al., Women's Lives After an HIV-Positive Diagnosis: Disclosure and Violence, 4 Maternal & Child Health J. 111, 116-17 (2000) (reporting that a study of 310 HIV-positive women found that 69% of the women experienced physical abuse as adults, 32% experienced sexual abuse as adults, and 45% experienced abuse after being diagnosed with HIV); Klein & Orloff, supra note 24, at 922 ("Domestic violence programs across the country are beginning to see growing numbers of battered women whose batterers have infected them with the HIV virus.").

[33] Blair Beadnell et al., HIV/STD Risk Factors for Women with Violent Male Partners, 42 Sex Roles 661, 679 (2000).

[34] The idea of the interrelationship of domestic violence and HIV/AIDS may evoke only thoughts of an abusive partner infecting the victim of violence. This is a troubling and real occurrence but is only part of the realm of HIV-related violence. This Part begins by describing the role of HIV status in domestic violence when the survivor is HIV-positive, giving examples of violence escalating after notifying a partner of one's status, using knowledge of status to exert control over a partner, and interfering with medical treatment. The Part goes on to describe the potential role of HIV in domestic violence when the batterer is HIV-positive. This structure highlights the occurrence of these less obvious uses of HIV status in violence, examines how domestic violence can be different when either partner is HIV-positive, and strives to avoid promoting an association of the abusive partner as HIV-positive.
Survivors have varied experiences of HIV/AIDS-related domestic violence, as demonstrated by considering the differences between the examples of sexual assault and destruction of HIV medication.

[35] "Partner notification" refers both to voluntary disclosure of HIV status to an intimate partner and disclosure that is required by partner notification laws. See, e.g., Mich. Comp. Laws Ann. § 333.5114a (West 2001) (stating the legal requirements of partner notification and the role of the local health department); Lawrence O. Gostin & James G. Hodge, Jr., Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification, 5 Duke J. Gender L. & Pol'y 9, 34-41 (1998) (describing the multiple meanings of partner notification). In abusive relationships, notification in either context may result in escalated violence. Literature primarily focuses on the consequences of notifying a partner after being prompted to by a health care provider. See, e.g., Matthew Carmody, Mandatory HIV Partner Notification: Efficacy, Legality, and Notions of Traditional Public Health, 4 Tex. F. on C.L. & C.R. 107, 111-14 (1999); Gostin & Hodge, Jr., supra, at 61-62; Richard L. North & Karen H. Rothenberg, Partner Notification and the Threat of Domestic Violence Against Women with HIV Infection, 329 New Eng. J. Med. 1194, 1195 (1993); Karen H. Rothenberg & Stephen J. Paskey, The Risk of Domestic Violence and Women with HIV Infection: Implications for Partner Notification, Public Policy, and the Law, 85 Am. J. Pub. Health 1569, 1573 (1995); Karen H. Rothenberg et al., Domestic Violence and Partner Notification: Implications for Treatment and Counseling of Women with HIV, 50 J. Am. Med. Women's Ass'n 87, 91 (2005).

[36] The nonreferenced examples that refer to clients, including the examples in italics, are from my experience representing survivors of intimate partner violence and will not receive further citation.

[37] Andrea Carlson Gielen et al., Women's Disclosure of HIV Status: Experiences of Mistreatment and Violence in an Urban Setting, Women & Health, July 1997, at 19, 20 (discussing women's fears of rejection, discrimination, and

violence and concerns about public ignorance of the disease).

38 See Susan B. Apel, Privacy in Genetic Testing: Why Women Are Different, 11 S. Cal. Interdisc. L.J. 1, 18-19 (2001) (finding that women living with a male partner were three times more likely to report violence as a result of their diagnosis, as compared with women living with a female partner, and citing a study of fifty HIV-positive women in which one-quarter of the sample reported negative consequences of disclosure, including physical assault); Roger Doughty, The Confidentiality of HIV-Related Information: Responding to the Resurgence of Aggressive Public Health Interventions in the AIDS Epidemic, 82 Cal. L. Rev. 113, 167-68 (1994) (finding that, for many women in abusive relationships, being diagnosed HIV-positive results in increased physical violence with a significant likelihood of further violence); Lichtenstein, supra note 30, at 710.

39 Gielen et al., supra note 32, at 116.

40 Apel, supra note 38, at 19.

41 Rothenberg & Paskey, supra note 35, at 1570 (reporting that eighteen percent of each of these providers' female clients had this concern).

42 Lichtenstein, supra note 30, at 710.

43 Gielen et al., supra note 37, at 27.

44 Gielen et al., supra note 32, at 117.

45 Leslie E. Wolf, Bernard Lo & Lawrence O. Gostin, Legal Barriers to Implementing Recommendations for Universal Routine Prenatal HIV Testing, 32 J.L. Med. & Ethics 137, 138 (2004) (citations omitted).

46 Apel, supra note 38, at 19.

47 Id. at 18.

48 See Doughty, supra note 38, at 167-68 (concluding that partner notification programs may directly increase the risk of domestic violence for women who are HIV-positive); Gielen et al., supra note 37, at 29-30 (discussing health professionals' and advocates' concerns about physical harm to a patient resulting from partner notification).

49 The legal scholarship addressing domestic violence and HIV infection almost exclusively focuses on the risk of violence following partner notification but does not discuss the other areas of HIV-related violence that are identified in this Article. See sources cited supra note 35.

50 Gielen et al., supra note 32, at 118.

51 See infra Part II.B for a discussion of social stigma and isolation. Survivors of intimate partner violence and HIV-positive individuals often experience isolation. An abusive partner may isolate the survivor by controlling whom she interacts with; distancing her from family, friends, and other forms of outside support; limiting her activities outside of the home or outside of his presence; controlling what she reads; and using jealousy to justify these actions. See, e.g., Lichtenstein, supra note 30, at 709. Individuals experiencing domestic violence in the context of HIV/AIDS may already face isolation, and threats to reveal private information that cause fear of how others will respond

further exacerbate the feeling of isolation.

52 Lichtenstein, supra note 30, at 710.

53 Laurie S. Kohn, Why Doesn't She Leave? The Collision of First Amendment Rights and Effective Court Remedies for Victims of Domestic Violence, 29 Hastings Const. L.Q. 1, 56 (2001) ("The speech, by its very utterance, may decimate the victim's personal or professional life. The destruction may be irreparable. Given societal biases, HIV and sexual orientation status may have severe social and professional repercussions."); see also infra Part II.B (examining stigma surrounding HIV/AIDS and how that stigma dissuades client testimony about her HIV/AIDS status).

54 See, e.g., Kohn, supra note 53, at 4-5 (including an amalgamation of client stories to illustrate the impossible dilemma many HIV-positive domestic violence survivors face).

55 Litigants with children may fear that a judge will improperly consider HIV status in awarding custody. Judges may question an HIV-positive parent's long-term ability to care for a child while coping with her own health issues and may base decisions solely on this factor, failing to consider the consequences of awarding custody to an abusive parent. Judges have denied custody and prohibited visitation based on a parent's HIV or AIDS status. Lauren Shapiro, An HIV Advocate's View of Family Court: Lessons from a Broken System, 5 Duke J. Gender L. & Pol'y 133, 133 (1998); see also Stewart v. Stewart, 521 N.E.2d 956, 964-67 (Ind. Ct. App. 1988) (holding that the trial court improperly terminated the father's visitation rights with his two-year-old daughter on the basis that the father presented a physical danger to his daughter because he had AIDS). The appellate court overturned the decision, noting that the decision was contrary to medical evidence at the time of trial. Stewart, 521 N.E.2d at 964-65. In considering the possibility that judges may rely on HIV or AIDS status in awarding custody, it is noteworthy that a dissenting judge wrote, "[I]t is theoretically possible for a parent to infect a child with the AIDS virus while extracting a child's tooth. Under these circumstances, a parent 'might' infect his child with AIDS." Id. at 967 (Conover, J., dissenting). If Mr. Stewart had not appealed the trial court's decision, he would have lost all contact with his daughter. Id. at 966 (majority opinion). Fear of an adverse custody ruling could prevent an HIV-positive parent from going to court or speaking about HIV-related aspects of violence. Examples from case law are of appeals, which require resources, protracted litigation, and often delays of many years. Id. at 958-59 (discussing the trial court decision, which came down in 1986, two years before the appellate decision).

56 See Brittney Johnson, Stigma Remains an Obstacle to Treatment: Counselors Say Fears Are Common Among Recent Latino Immigrants, Wash. Post, Aug. 5, 2008, at F4 (explaining how current laws that prohibit HIV-positive individuals from entering the United States or obtaining legal residency discourage immigrants from being tested or treated for HIV/AIDS).

57 The Introduction to this Article briefly noted this example.

58 Current treatment for HIV combines three or more medicines in a regimen. The type, number of pills, and frequency vary with each patient. See Ctrs. for Disease Control & Prevention, Dep't of Health & Human Servs., Living with HIV/AIDS, http://cdc.gov/hiv/resources/brochures/livingwithhiv.htm (last visited Apr. 8, 2009).

59 See Bronwen Lichtenstein, Domestic Violence in Barriers to Health Care for HIV-Positive Women, 20 AIDS Patient Care & STDs 122, 123 (2006). HIV treatment relies on the patient's compliance in taking prescribed dosages of particular combinations of medicines. Treating HIV infection with antiretroviral drugs requires tremendous commitment and the ability to closely follow a prescribed regimen. Missing doses allows HIV to multiply more easily and mutations to occur, which increases the possibility of developing HIV- or AIDS-related infections and heightens the chance of developing resistance to antiretroviral medications. Id.; N.M. AIDS Educ. & Training Ctr., Fact Sheet 103: Acute HIV Infection (Oct. 31, 2008), available at http://www.aidsinfonet.org/uploaded/factsheets/5_eng_103.pdf; see also U.S. Dep't of Health & Human Servs., HIV and Its Treatment: What You Should Know 13 (Dec. 2008), available at http://aidsinfo.nih.gov/contentfiles/HIVandItsTreatment_ cbrochure_en.pdf (explaining that when a person misses even one medication dose, the virus can reproduce more rapidly, and warning, "[k]eeping HIV replication at a

minimum is essential for preventing AIDS-related conditions and death").
Overall health and long-term prognosis improve when HIV-positive individuals begin taking antiretroviral medications as prescribed at early stages of infection. Lichtenstein, supra, at 123 (stating that harm occurs during the early stages of HIV infection, making early medical attention important); N.M. AIDS Educ. & Training Ctr., supra (explaining how the immune system weakens and a person's health is negatively affected even before he or she tests positive for HIV).

60 Other barriers to health care include illness that prevents going to a health care site; shame from being abused; psychological stressors resulting from violence, including depression; and the fear that medical professionals may have stigmatizing attitudes toward abuse victims. See Lichtenstein, supra note 59, at 122-23; see also Bogart et al., supra note 30, at 325 (noting that victims of domestic violence have problems accessing healthcare). See generally Cohen et al., supra note 32, at 564 ("Women who are HIV infected and are enduring the psychosocial effects of abuse and violence may not make complying with medication their highest priority. Providers ... may not fully recognize, understand, or accept that women who are in, or recovering from, abusive relationships are sometimes unable to comply with such [complex medical] regimens.").

61 Symposium, supra note 10, at 150-51.

62 This occurs with the use of a double cylinder deadbolt, which requires a key to open it from either side.

63 Frequent medical appointments are necessary to monitor cell count and viral load. Viral load must be tested before beginning a medication, two to eight weeks after starting a medication, and every three to four months afterward. N.M. AIDS Educ. & Training Ctr., Fact Sheet 125: Viral Load Tests (Sept. 28, 2007), available at http://www.aidsinfonet.org/uploaded/factsheets/14_eng_125.pdf. Immune system cell counts should be tested every three to six months. Id.

64 "Condom negotiation" has been defined as "(a) a woman's persuasion of a male sexual partner to use a condom or (b) a woman's decision to abstain from sex when a male partner refuses to use a condom for [HIV and] AIDS prevention." Yolanda R. Davila, Influence of Abuse on Condom Negotiation Among Mexican-American Women Involved in Abusive Relationships, 13 J. Ass'n Nurses in AIDS Care 46, 46 (2002). This term is used in medical literature and public health studies. In domestic violence relationships, the term distorts reality, because there is often not a genuine possibility to "negotiate" with an abusive partner.

65 Id. at 52.

66 Id.

67 Amaro, supra note 16, at 441 ("In nearly 75% of 69 women-only focus groups, the issue of power and gender roles emerged as a central barrier to risk reduction. Women ... referred to men's stubbornness and unwillingness to use condoms and expressed feelings of powerlessness, low self-esteem, isolation, lack of voice, and inability to affect risk reduction decisions or behaviors.").
Condoms are a classic form of birth control, and part of what makes requests for condom use difficult is that "negotiation" implicates issues of both reproduction and disease prevention. See, e.g., id. (discussing the impact of gender roles in pregnancy prevention and HIV risk reduction).

68 Id. at 440.

69 Nabila El-Bassel et al., Fear and Violence: Raising the HIV Stakes, 12 AIDS Educ. & Prevention 154, 160 (2000). In a study of HIV risks and intimate partner violence, participants' partners understood their attempts to use condoms as suggesting infidelity. Id. By trying to avoid HIV risks by using female condoms, the women concluded that they enraged their partners and faced further abuse. Id.

[70] Id.

[71] Although the public health message to women is to prevent AIDS through condom use, abuse survivors are often not in a position to negotiate condom use. See, e.g., Davila, supra note 64, at 51; Davila & Brackley, supra note 27, at 334.

[72] See Amaro, supra note 16, at 444.

[73] Multiple studies have found that women with abusive partners are more likely than others to report never using condoms or using condoms infrequently. See, e.g., Cynthia H. Chuang et al., Association of Violence Victimization with Inconsistent Condom Use in HIV-Infected Persons, 10 AIDS & Behav. 201, 204 (2006).

[74] Gielen, et al., supra note 30, at 113; see also Suzanne Maman et al., The Intersections of HIV and Violence: Directions for Future Research and Interventions, 50 Soc. Sci. & Med. 459, 473 (2000) (reporting that a 1997 study found that when women who had a physically abusive partner asked the partner to use condoms, these women were 4.2 times more likely to be verbally abused, 9.2 times more likely to be threatened with physical abuse, and 3.7 times more likely to be threatened with abandonment than women in relationships with no history of abuse).

[75] Novello & Soto-Torres, supra note 8, at 20-22; see also North & Rothenberg, supra note 35, at 1195 ("Promoting the use of condoms has been linked to an increased risk of violence for the most vulnerable women who may already be victims of sexual or physical abuse.").

[76] See Beadnell et al., supra note 33, at 678 ("Physically abused women were more likely to endorse that their partners had more say about safer sex, that they had sex when they did not want to, and that their partner had or might have other sex partners."); Davila, supra note 64, at 53.

[77] The possibility of HIV infection increases because of the physical trauma during rape. Lichtenstein, supra note 30, at 710 (explaining how abrasions and vaginal tears that result from forced sex are a conduit for HIV infection); see also Jacquelyn C. Campbell, Health Consequences of Intimate Partner Violence, 359 Lancet 1331, 1332 (2002) (detailing the prevalence of gynecological problems, sexually transmitted diseases, and vaginal infection among abused women, and finding that abused women were three times more likely to experience these problems than women who were not abused).

[78] See Klein & Orloff, supra note 24, at 922; see also Dunkle et al., supra note 32, at 1419 (finding that women who are physically and sexually assaulted by a male intimate partner have an increased risk of HIV infection and that this association is true even after adjusting for risk behaviors); Gielen, et al., supra note 30, at 107 (discussing how histories of abuse, including forced sex, are associated with increased risks for sexually transmitted diseases).

[79] Lichtenstein, supra note 30, at 709.

[80] Sexual assault occurs in nineteen percent of incidents of domestic violence. See Nat'l Coal. Against Domestic Violence, Sexual Assault and Violence Fact Sheet (2007) (on file with the North Carolina Law Review) (describing stalking, sexual violence, homicide, and physical abuse as part of domestic violence). Because there is a high degree of underreporting of domestic violence and sexual assault, the statistics in this section are likely lower than reality.

[81] Klein & Orloff, supra note 24, at 922 n.765 (citing Women's Action Coalition, WAC Stats: The Facts About Women 49, 55 (1993)).

[82] Nat'l Coal. Against Domestic Violence, supra note 80 ("Sexual assault or forced sex occurs in approximately 40-45% of battering relationships.").

[83] Patricia Tjaden & Nancy Thoennes, U.S. Dep't of Justice, Extent, Nature, and Consequences of Intimate Partner Violence 39-40 (2000) (reporting that 51.2% of women who were raped by an intimate partner were raped multiple times by the same partner).

[84] One study found that men who abuse their intimate partners are more likely to have multiple sexual partners at once. Dunkle et al., supra note 32, at 1419.

[85] See, e.g., U.N. Sec'y Gen.'s Task Force on Women, Girls and HIV/AIDS in S. Afr., Facing the Future Together 16 (2004) ("[T]he close ties between violence and HIV are very clear--fearful of provoking further abuse from violence partners, women feel even less able to ... demand fidelity.").

[86] See Josette M. LeDoux, Interspousal Liability and the Wrongful Transmission of HIV-AIDS: An Argument for Broadening Legal Avenues for the Injured Spouse and Further Expanding Children's Right to Sue Their Parents, 34 New Eng. L. Rev. 392, 432 (2000).

[87] See id.

[88] Id.

[89] Kelly, supra note 7, at 439 (citing Women's Rights Div., Human Rights Watch, Just Die Quietly 21 (2002)) A woman in Uganda recounted, "In [HIV/AIDS] counseling they told us [the wives] about condoms but he didn't want to use them because he didn't want to leave us alive to remarry." Id.

[90] Lichtenstein, supra note 30, at 709.

[91] See Mahoney, supra note 2, at 5-6 (defining "separation assault" and explaining that the moment a survivor attempts to leave an abusive relationship is the point of highest danger and lethality, because abusive partners often engage in deliberate acts to exert control and terrorize the partner into not leaving).

[92] Cynthia Knox, Domestic Violence and HIV Mandatory Reporting, 29 Fordham Urb. L.J. 150, 150 (2001).

[93] Gielen et al., supra note 24, at 179.

[94] Lichtenstein, supra note 30, at 707.

[95] El-Bassel et al., supra note 69, at 165. Deeper discussion of domestic violence and drug use is beyond the scope of this Article. It should be noted that individuals who are addicted to drugs may still engage in safe sex practices and use condoms. See, e.g., Sylvia A. Law, Commercial Sex: Beyond Decriminalization, 73 S. Cal. L. Rev. 523, 550 n.145 (2000) (citing a study reporting the frequency of condom use by women who are addicted to drugs).

[96] The early "excluded voice" narratives accomplished social recognition of problems affecting women and pushed courts and the legal realm to respond to these gendered problems. Kathryn Abrams, Hearing the Call of Stories, 79 Cal. L. Rev. 971, 1033 (1991). These narratives "offered the stories of women who were victims of some gender-specific injury, whose voices had not been heard in social discussions of a problem, or in legal discussions of the proper remedial response." Id.; see also Christopher P. Gilkerson, Poverty Law Narratives: The Critical Practice and

Theory of Receiving and Translating Client Stories, 43 Hastings L.J. 861, 865 n.10 (1992) ("Storytelling can be a method for revealing realities of experience and oppression often hidden by legal principles and process.").

97 Domestic violence has historically been ignored and condoned, and a meaningful response to domestic violence by the state is relatively recent. Historically, a husband was permitted to chastise his wife and would not face punishment unless he killed or maimed her. The state would not intrude upon the private family sphere, and state action focused on preserving the family structure and rejected intervention. In the late nineteenth century, the women's movement and temperance activists succeeded in changing the laws so that a husband no longer had a "right" to beat his wife; however, spousal abuse continued to be ignored until the 1960s and 1970s. See Jane C. Murphy, Lawyering for Social Change: The Power of the Narrative in Domestic Violence Law Reform, 21 Hofstra L. Rev. 1243, 1262 (1993); Reva B. Siegel, "The Rule of Love": Wife Beating as Prerogative and Privacy, 105 Yale L.J. 2117, 2118 (1996).

98 Sheppard & Westphal, supra note 5, at 352.

99 See Lisa A. Goodman & Deborah Epstein, Listening to Battered Women: A Survivor-Centered Approach to Advocacy, Mental Health, and Justice 31 (2008) (arguing persuasively for a return to the principles of the early feminist movement, encouraging advocates to listen to individual women's voices, to strive for women's empowerment and equality, and to create supportive communities and opportunities for battered women to share their experiences).

100 See Judith Lewis Herman, Trauma and Recovery 2 (1992).

101 Id.

102 See Jane C. Murphy, Engaging with the State: The Growing Reliance on Lawyers and Judges to Protect Battered Women, 11 Am. U. J. Gender Soc. Pol'y & L. 499, 501 (2003) (describing the shift from establishing shelters and safe houses to focusing on legal protections for abuse victims).

103 See generally Developments in the Law: Legal Responses to Domestic Violence, 106 Harv. L. Rev. 1498, 1528-29 (1993) (explaining that, until the 1970s, the only legal remedy for spousal abuse was an injunction issued pursuant to a divorce or legal separation).

104 Goodman & Epstein, supra note 99, at 33 (reporting that, by 1993, each state had enacted a protection order statute). Protection orders represent "the intersection of traditional community-based and justice system approaches: victim empowerment coupled with deterrence. A [civil protection order] combines a victim-initiated intervention with the power of enforcement by the criminal justice system." Michelle R. Waul, Civil Protection Orders: An Opportunity for Intervention with Domestic Violence Victims, 6 Geo. Pub. Pol'y Rev. 51, 53 (2000).
Statutes vary by state, but in general, orders of protection are available to litigants with a qualifying relationship, such as a romantic relationship or blood relationship, when a qualifying criminal offense has occurred, such as an assault or threat to do bodily harm. See, e.g., D.C. Code § 16-1005 (2001). These are civil cases, and they commonly use the legal standard of a preponderance of the evidence. Id. Civil protection orders offer wide-ranging injunctive relief. Orders may require a respondent to not abuse, threaten, harass, or destroy the property of the petitioner and children; to stay away from the petitioner and listed locations; to refrain from contacting the petitioner; to vacate a shared residence; to undergo drug, alcohol, and domestic violence counseling; and to make payments for medical expenses, property damage, or attorney's fees. Id. Protection orders may include awards of child custody, child support, visitation, property, and alimony or maintenance. Id. Judges may also award other relief that is necessary to resolve conflict and prevent violence.

105 Murphy, supra note 97, at 1262-63. Legal developments in addition to civil protection orders and misdemeanor domestic violence statutes include laws abolishing interspousal tort immunity, repealing the marital rape exemption, recognizing stalking as a crime, strengthening arrest policies and prosecutorial response, creating child custody and visitation domestic violence presumptions, and implementing the Violence Against Women Act. See generally

Developments in the Law, supra note 103, at 1530-44 (describing developing state and federal responses to domestic violence).

106 Much of the current focus of the anti-domestic violence movement is on improving domestic violence laws and is centered in the courts, with an emphasis on judicial training, court monitoring programs, domestic violence intake centers that bring together civil and criminal justice system advocates, implementation meetings for recently created dedicated domestic violence courts, and law reform. This Article focuses on the courts because such a large number of survivors turn to the courts each year for protection, and the relief provided by judges is important to prevent future violence. The centrality of the legal system in the overall community response to violence may in part be attributable to resources. Whereas there are a limited number of shelters for abuse survivors, and shelters have capacity restrictions and waitlists, in the courthouse, the dockets simply grow longer.

107 See, e.g., Metropolitan Police Department, Keeping Yourself Safe with Protection Orders, http://mpdc.dc.gov/mpdc/cwp/view,a,1232,Q,541166, mpdcNav_GID,1557.asp (last visited Apr. 8, 2009) (providing information for the procurement of an Order of Protection in the District of Columbia).

108 Klein & Orloff, supra note 24, at 813; see Matthew J. Carlson, Susan D. Harris & George W. Holden, Protective Orders and Domestic Violence: Risk Factors for Re-Abuse, 14 J. Fam. Violence 205, 211, 214-15, 220, 224 (1999) (describing a study of 210 relationships in which the victim had obtained a protection order, and finding that, based on tracking police reports before and after receiving the protection order, there was a significant decline in the probability of abuse following the issuance of a protection order); Victoria L. Holt et al., Do Protection Orders Affect the Likelihood of Future Partner Violence and Injury?, 24 Am. J. Preventive Med. 16, 18, 20-21 (2003) (concluding that domestic violence survivors who obtain civil protection orders have a decreased likelihood of subsequent physical and nonphysical intimate partner violence, including significantly decreased risk of contact by the abusive partner, weapon threats, injuries, and abuse-related medical treatment); Judith McFarlane et al., Protection Orders and Intimate Partner Violence: An 18-Month Study of 150 Black, Hispanic, and White Women, 94 Am. J. Pub. Health 613, 616-17 (2004) (finding significant reductions in threats to do bodily harm, physical assaults, stalking, and worksite harassment among women who sought and qualified for protection orders, regardless of whether the orders were granted). But cf. Adele Harrell & Barbara E. Smith, Effects of Restraining Orders on Domestic Violence Victims, in Do Arrests and Restraining Orders Work? 214, 218, 231-32 (Eve S. Buzawa & Carl G. Buzawa eds., 1996) (discussing a 1991 study on abuse following the issuance of a protection order). While eighty-six percent of abused women reported that the temporary protection order was "very helpful" or "somewhat helpful," less than half of the women thought the abusive partner knew he had to obey the order. Id. at 218. The study found that the severity of abuse prior to the issuance of the order is predictive of the severity of abuse that occurs after the court issues a protection order. Id. at 231; Murphy, supra note 102, at 510-14 (recognizing that battered women use multiple legal and nonlegal strategies to prevent violence; that obtaining only an emergency temporary protection order achieves some women's goals; and that significant institutional barriers and the lack of representation make it difficult for many litigants to complete the protection order process).

109 Each year, approximately twenty percent of the 1.5 million victims of domestic violence obtain civil protection orders. Victoria L. Holt et al., Civil Protection Orders and Risk of Subsequent Police-Reported Violence, 288 J. Am. Med. Ass'n 589, 589, 593 (2002) (finding that permanent protection orders are associated with a significant decrease in police-reported domestic violence); see also Tjaden & Thoennes, supra note 83, at 54 (reporting the National Violence Against Women survey result that, each year, approximately 1,132,000 victims of intimate partner rape, physical assault, and stalking obtain civil protection orders or restraining orders against their abusers); Murphy, supra note 102, at 502-03 (stating that civil protection orders are "one of the most commonly used legal remedies for battered women" and discussing how judicial remedies are further encouraged by the allocation of millions of dollars to civil legal assistance for battered women in the Violence Against Women Act of 2000).

110 See, e.g., Cohen et al., supra note 32, at 560; El-Bassel, supra note 69, at 160; supra Part I.B.

111 Seeking help in domestic violence court is challenging from a psychological perspective. In addition, many petitioners experience housing and employment discrimination when landlords and employers think the survivor's presence makes the environment unsafe due to the abusive partner's violence. Some petitioners worry they will be fired if they take time off from work for court proceedings, and others fear court records will be discovered and future landlords and employers will discriminate against them. Even with the advent of laws prohibiting housing and

employment discrimination against abuse victims, studies have shown that bias continues. See Nina W. Tarr, Employment and Economic Security for Victims of Domestic Abuse, 16 S. Cal. Rev. L. & Soc. Just. 371, 375-78 (2007) (detailing problems with employment security experienced by survivors of domestic violence and how abuse victims are typically not protected under current employment discrimination laws); Sylvia Moreno, Abuse Victims Face Bias, Study Says, Wash. Post (District Extra), May 8, 2008, at 1 (describing housing discrimination that abuse survivors face).

112 Scott Burris, Studying the Legal Management of HIV-Related Stigma, Am. Behav. Scientist, Apr. 1999, at 1232, 1239-40 ("[T]he individual's perception of social risk ... and how to manage that perceived risk occur within a context of anxiety, stigma, subordination, and struggle on the various fields of the individual's life activity.").

113 Gielen et al., supra note 32, at 111.

114 Pre-determining that individuals who are HIV-positive or who have AIDS want to keep their status private could be considered further stigmatizing or suggest that the health status is shameful. In the United States, medical information is considered confidential, and individuals should have control over the public dissemination of their own health information. See 45 C.F.R. § 164.512 (2008) (detailing the privacy of individuals' health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")).

115 See infra Part II.B.3.

116 See Robin Sheridan, Comment, Public Health Versus Civil Liberties: Washington State Imposes HIV Surveillance and Strikes the Proper Balance, 24 Seattle U. L. Rev. 941, 949 (2001) (discussing how entire families have lost their housing after the discovery that one member is HIV-positive). HIV-infected individuals have faced discrimination in housing, both on individual levels and with communities opposing homes and shelters for those with AIDS. Id. See generally Stewart B. McKinney Found. v. Town Plan & Zoning Comm'n of Fairfield, 790 F. Supp. 1197 (D. Conn. 1992) (finding that, by requiring special exceptions for the use of two-family residences as homes for HIV-infected persons, the zoning commission violated the Fair Housing Act). The community response included discriminatory remarks made by neighbors; a public information forum attended by 200 people, where the crowd was hostile and "riotous;" and task force meetings to oppose any residence for HIV-infected persons in the town. Id. at 1203-05. The judge cited the "extreme fear the HIV virus engenders and the misconceptions held by so many." Id. at 1220; see also Downtown Hosp. (Booth House) v. Sarris, 588 N.Y.S.2d 748 (N.Y. Civ. Ct. 1992) (providing an additional example of landlords evicting tenants because the tenants had AIDS).

117 See, e.g., Chalk v. U.S. Dist. Court, 840 F.2d 701, 703-04 (9th Cir. 1988); Ray v. Sch. Dist. of DeSoto County, 666 F. Supp. 1524, 1528, 1534-35 (M.D. Fla. 1987); Thomas v. Atascadero Unified Sch. Dist., 662 F. Supp. 376, 379, 381-82 (C.D. Cal. 1987); see also William L. Earl & Judith Kavanaugh, Meeting the AIDS Epidemic in the Courtroom: Practical Suggestions in Litigating Your First AIDS Case, 12 Nova L. Rev. 1203, 1209-10 (1988) (describing how HIV-positive children and teachers were excluded from schools even though there had been no cases of transmission through casual contact in schools or daycare centers).

118 See, e.g., Stewart B. McKinney Found., 790 F. Supp. at 1203-04; Sheridan, supra note 116, at 949; see also sources cited infra note 120 (discussing ostracization in the employment context).

119 See Sheridan, supra note 116, at 949; Johnson, supra note 55.

120 See 2 L. Camille Hebert, Employee Privacy Law § 11:6 (2006) (citing Robert J. Blendon & Karen Donelan, Discrimination Against People with AIDS: The Public's Perspective, 319 New Eng J. Med. 1022, 1023-24 (1988)). Blendon & Donelan's article discusses a compilation of surveys conducted in 1988 reporting on views of persons with AIDS as "offenders who were getting their rightful due" and who should be isolated from the rest of society; one in four persons indicated that they would refuse to work alongside of a person with AIDS and that employers should have a right to fire persons based on having AIDS. Blendon & Donelan, supra, at 1023-24. This author deeply hopes that responses to persons with HIV/AIDS have progressed beyond early alarmist attitudes reflected in these

surveys.

[121] See Sheridan, supra note 116, at 949.

[122] Doe v. Se. Pa. Transp. Auth., 72 F.3d 1133, 1140 (3d Cir. 1995).

[123] In the District of Columbia, the Domestic Violence Intake Center, located at the Superior Court, is a centralized location for services for abuse survivors. It is commonly the entry point to the civil and criminal justice systems, and advocacy services are also available. See infra Part III.D for additional explanation.
Supervising attorneys and certified student attorneys from local law school domestic violence clinics are present at the intake center many days of the week. They meet petitioners and begin representation from the moment someone seeks help. Student attorneys interview the client, learn about the client's goals, explain various legal and nonlegal options, and help the client evaluate the consequences of each option. The student attorneys, together with the client, draft the petition for a protection order.

[124] See Kit Kinports & Karla Fischer, Orders of Protection in Domestic Violence Cases: An Empirical Assessment of the Impact of the Reform Statutes, 2 Tex. J. Women & L. 163, 212-13 (1993) (reporting that approximately six percent of respondents said that judges in their jurisdictions refused to allow observers in the courtrooms during domestic violence hearings).
While almost all protection order cases occur in public courtrooms, lawyers report some practices they employ to make their clients' trials less of a public spectacle. Attorneys have requested to be heard just before the lunch hour so that the judge can dismiss those waiting for their cases to be heard until after lunch, or have asked for their cases to be the last of the day. There are rare reports of judges holding hearings in chambers. Holding hearings in chambers is not a widespread practice, but this judicial response is telling.

[125] Domestic violence litigants in general may be concerned about revealing personal, sensitive information in a public courtroom. The suggestions infra may address these concerns for a multitude of litigants, including individuals who are not affected by HIV or AIDS.

[126] D.C. Super. Ct. Domestic Violence Unit, 2007 Domestic Violence Statistical Summary, http://www.dccourts.gov/dccourts/docs/statistics/2007DomesticViolence.pdf (last visited Apr. 8, 2009) (reporting that the Domestic Violence Unit handled 4,393 protection order cases and 3,900 misdemeanor domestic violence cases in the year 2007).
In the District of Columbia, there is a dedicated Domestic Violence Unit, with two courtrooms for civil protection order cases, two courtrooms for domestic violence misdemeanor cases, and one courtroom where a magistrate judge handles arraignments and hears requests for temporary protection orders. I have litigated domestic violence cases in D.C. Superior Court for the past five years. I observed similarly crowded courtrooms while working at legal services offices in Kansas City, Missouri, and Chicago, Illinois. It is not uncommon for twenty to forty cases to be assigned to one judge on any given day. Because all litigants are told to arrive at the same time (in the District of Columbia, for example, everyone is instructed to arrive at 8:30 a.m.), masses of people congregate outside of the courtrooms, and once the courtrooms open (usually around 9:00 a.m.), a full audience listens as cases are called.

[127] Temporary protection orders are emergency orders that are in place for a limited period of time--typically ten days to three weeks--before the protection order hearing. Temporary or emergency orders are typically awarded after an ex parte hearing on the initial day a petitioner seeks legal protection from violence. See, e.g., D.C. Code § 16-1004(d)(1)(2001).

[128] This is true of this particular petitioner and of other clients.

[129] Email from Adrienne Lockie, Practitioner-in-Residence, American University, Washington College of Law, in Washington, D.C. (Feb. 9, 2009, 12:08 EST) (on file with the North Carolina Law Review) (discussing her experience representing domestic violence survivors in New Jersey).

[130] Beverly Balos, Domestic Violence Matters: The Case for Appointed Counsel in Protective Order Proceedings, 15 Temp. Pol. & Civ. Rts. L. Rev. 557, 568 (2006).

[131] The psychological effects of domestic violence, including high rates of depression and post-traumatic stress disorder, are now well understood. See generally Herman, supra note 100, at 74-95 (discussing situations of captivity as examples of prolonged and repeated trauma).

[132] Peter Margulies, Representation of Domestic Violence Survivors as a New Paradigm of Poverty Law: In Search of Access, Connection, and Voice, 63 Geo. Wash. L. Rev. 1071, 1099 (1995) (explaining that battered women often experience high levels of stigma and isolation based on a range of experiences, including denial; fear; the isolation caused by abusive partners who literally hold the women hostage, monitoring their every movement and limiting contact with family and friends; and the survivors' own long-practiced survival skills).

[133] Deborah Epstein, Margret E. Bell & Lisa A. Goodman, Transforming Aggressive Prosecution Policies: Prioritizing Victims' Long-Term Safety in the Prosecution of Domestic Violence Cases, 11 Am. U. J. Gender Soc. Pol'y & L. 465, 481 (2003); see also Herman, supra note 100, at 72 ("If one set out by design to devise a system for provoking intrusive post-traumatic symptoms, one could not do better than a court of law."); Sarah M. Buel, Domestic Violence and the Law: An Impassioned Exploration for Family Peace, 33 Fam. L.Q. 719, 719 (1999) (reflecting on her experience in an abusive relationship and the treatment she received when seeking help from the courts). Buel writes, "I was determined to ensure that other victims did not share my experiences of shame, humiliation, sorry excuses, and endangerment by my abuser and the legal system." Id.

[134] Kinports & Fischer, supra note 124, at 213. Similarly, a survey by the National Women's Study showed that sixty-six percent of rape victims would be more likely to report their rape if they knew their identity would be protected. In the survey, seventy-six percent of women overall and seventy-eight percent of the rape victims surveyed were in favor of legislation that prohibited the media from disclosing the names of rape victims. Deborah W. Denno, The Privacy Rights of Rape Victims in the Media and the Law, Perspectives on Disclosing Rape Victims' Names, 61 Fordham L. Rev. 1113, 1130-31 (1993) (citations omitted).

[135] Abused women often find it challenging to openly discuss the abuse with prosecutors, judges, and a courtroom audience, and report being emotional and confused. Epstein et al., supra note 133, at 473-74; Kinports & Fischer, supra note 124, at 204 (reporting that, in a study of women seeking protection orders against their abusive partners, 57.2% of abused women said the courthouse environment was so intimidating that it was difficult for them to describe their experiences of abuse and to explain what they needed). As evidenced by the previous sources, abuse is often a difficult subject to talk about, and coupling that with the stigmatizing nature of HIV/AIDS only compounds the problem.

[136] The petitioner could face a lawsuit for invasion of privacy or the intentional infliction of emotional distress if she publicly reveals that her partner is HIV-positive. Kohn, supra note 53, at 8; see also infra Part III.A (analyzing privacy interests further).

[137] People view their experiences in the justice system more favorably and are more likely to comply with court orders when they are allowed to present their case and when they feel that judges are treating them with dignity and respect and are attempting to be fair. This ability to express oneself affects compliance with orders, even when the decision is unfavorable. See Deborah Epstein, Procedural Justice: Tempering the State's Response to Domestic Violence, 43 Wm. & Mary L. Rev. 1843, 1875-79, 1905 (2002) (discussing John Braithwaite's shaming theory, which holds that sanctions imposed in a respectful manner may increase compliance, whereas sanctions imposed in a manner without considering human dignity may encourage future offending).

[138] Clients typically also have strong desires to protect this information about the HIV status of their partner. Even when the abusive partner is HIV-positive and the victim is not, clients recognize the potential social and professional harm to the batterer of making his HIV status public knowledge. Clients express understanding of the health issues with which the batterer is contending and the emotional distress he is already under due to his illness, and they do not want to cause further anguish.

[139] See, e.g., Zanita E. Fenton, Mirrored Silence: Reflections on Judicial Complicity in Private Violence, 78 Or. L. Rev. 995, 1026 (1999) ("Law is intended to stigmatize and exclude offenders through prosecution, trial and imprisonment; instead, silence serves to stigmatize and exclude the victims. Violence and its potential use are the unspoken means of maintaining silence." (citations omitted)).

[140] As Delgado succinctly states, "The therapy is to tell stories." Richard Delgado, Storytelling for Oppositionists and Others: A Plea for Narrative, 87 Mich. L. Rev. 2411, 2437 (1988).

[141] See, e.g., Jamie L. Wacks, A Proposal for Community-Based Racial Reconciliation in the United States Through Personal Stories, 7 Va. J. Soc. Pol'y & L. 195, 205-06 (2000) (arguing that, by telling their stories before truth commissions after apartheid in South Africa, individuals broke through silence, experienced a cathartic moment, and began a healing process following the brutal apartheid system).

[142] Even when emergency temporary protection orders are issued ex parte, "allowing the woman to tell her story to a sensitive judge and having the court validate the seriousness of the abuse might serve as an important symbol of the judicial system's commitment to end domestic violence and might also have therapeutic value for the petitioner." Kinports & Fischer, supra note 124, at 213 n.194.

[143] Leigh Goodmark, Telling Stories, Saving Lives: The Battered Mothers' Testimony Project, Women's Narratives, and Court Reform, 37 Ariz. St. L.J. 709, 756 (2005) (quoting a participant in the Battered Mothers' Testimony Project who spoke about the importance of sharing experiences and having these experiences validated).

[144] See Mary P. Koss, Blame, Shame, and Community: Justice Responses to Violence Against Women, 55 Am. Psychologist 1332, 1332 (2000).

[145] See Sheppard & Westphal, supra note 5, at 349 (arguing that, in a judge's findings, "[t]his judicial retelling legitimates and validates her story, and it is rendered more believable when funneled through institutionally sanctioned authority").
Many cases are resolved through negotiation, but even when a settlement contains all of the relief a client sought--sometimes relief extending beyond what a judge would likely order--this settlement might feel like a hollow victory because the client was not able to tell her story to the judge and never heard the judge say, "I credit the petitioner's testimony," or "I find that the respondent committed multiple criminal offenses," and issue findings in her favor. With the crowded court docket and a consent agreement, the petitioner is not heard.

[146] Kinports & Fischer, supra note 124, at 183.

[147] See, e.g., Martha Minow, Between Vengeance and Forgiveness: Facing History After Genocide and Mass Violence 66 (1998) ("Facing, rather than forgetting, the trauma is crucial if a victim hopes to avoid reproducing it in the form of emotional disturbances."); Kimberle Crenshaw, Race, Gender, and Sexual Harassment, 65 S. Cal. L. Rev. 1467, 1472 (1992) ("To speak, one risks the censure of one's closest allies. To remain silent renders one continually vulnerable to the kinds of abuses heaped upon people who have no voice."); Sheppard & Westphal, supra note 5, at 342 (describing speaking out about violence as a "strategy for survival," a crucial therapeutic method, and a political strategy for those who choose to become activists).
Author, playwright, and activist Eve Ensler wrote about her experience interviewing women at a hospital in the Congo where the women were treated after being brutally raped and mutilated. In the Congo, Ensler quickly realized how important it was to the women to have the opportunity to tell their stories. Ensler wrote:
Nadine holds onto my hand as if she were drowning in a tsunami of memory. As devastated as she is, it is clear that she needs to be telling this story, needs me to listen to what she is saying .... I stay for a week at Panzi. Women line up to tell me their stories. They come into the interview numb, distant, glazed over, dead. They leave alive, grateful, empowered. I begin to understand that the deepest wound for them is the sense that they have been forgotten, that they are invisible and that their suffering has no meaning. The simple act of listening to them has enormous impact. The slightest touch or kindness restores their faith and energy.

Eve Ensler, Women Left for Dead--and the Man Who's Saving Them, Glamour, Sept. 2007, at 288, 290, 292.

148 Lichtenstein, supra note 30, at 710 ("Disclosing an HIV-positive status to trusted friends and family members was a particularly important step in reclaiming broken lives, and the women who did so were usually able to garner support in order to regain their freedom.").

149 Herman, supra note 100, at 1.

150 Id. at 155 (discussing the common pathway for each recovery process).

151 Id. at 70. These stages have been recognized as important to surviving a range of traumas. See, e.g., Wacks, supra note 141, at 205 ("While a victim's act of telling her story is an extremely personal moment, the telling of this story in a public forum involves the community so that 'the seemingly private experience' becomes 'a public one.'" (quoting Minow, supra note 147, at 67)). Indeed, "[t]his public telling also sent a message of inclusion to those victims who felt excluded from society." Id. at 205. Wacks observes that Holocaust survivors report similar significance in telling their stories to others. Id. at 206.

152 "Doing power" is a phrase used by Martha Mahoney. See Mahoney, supra note 2, at 53 (quoting Jan E. Stets, Domestic Violence and Control 10 (1998)).

153 Martha Minow, Words and the Door to the Land of Change: Law, Language, and Family Violence, 43 Vand. L. Rev. 1665, 1688 (1990).

154 See Abrams, supra note 96, at 992-93; see also Mahoney, supra note 2, at 93. Mahoney's identification and naming of "separation assault" gave the public "conceptual access to a neglected and misrepresented social problem, much the way coining the term 'date rape' helped to expand public understanding of the varieties of sexual assault." Abrams, supra note 96, at 992-93. "Identifying separation assault could also have implications for the substantive law and litigation of cases involving spousal abuse." Id.

155 This Article is not advocating that HIV status must always be disclosed. If there is a connection between the HIV status and violence, and the survivor of violence wants the court to understand this, mechanisms could be used to safely reveal this information and minimize risks associated with revealing HIV status. See Gielen et al., supra note 37, at 29 ("[A] blanket policy of encouraging all women to disclose their status may put some women at significant risk.").

156 For example, in the District of Columbia, all of the litigants for the two civil domestic violence courtrooms are required to arrive by 8:30 a.m. The courtrooms typically open shortly after 9:00 a.m., and judges take the bench close to 9:30 a.m. Petitioners and respondents are inevitably in close contact with each other. See D.C. Super. Ct. Domestic Violence Unit, supra note 126.

157 Family law cases, including divorce, annulment, child custody, child support, adoption, and abuse and neglect matters, are scheduled individually. See, e.g., Divorce Practice & Procedure in the Circuit Courts of Montgomery County & Floyd County, Local Rules of Court (Feb. 5, 2004), http://www.montva.com/departments/courts/circcourt/divorce.php (describing the scheduling practices of the court, and, in § I.S, requesting the parties to consult with each other to recommend dates and times for hearings). Clerks manage judges' calendars, and judges and clerks schedule hearings and trials, often with input from the parties. See id. Parties are provided with a date and time to appear for hearings and trials. See id. § I.S.

158 See, e.g., Phyliss Craig-Taylor, Lifting the Veil: The Intersectionality of Ethics, Culture, and Gender Bias in Domestic Violence Cases, 32 Rutgers L. Rec. 31, 44 (2008), http://lawrecord.typepad.com/rutgers_law_record/files/Lifting_the_Veil_article_Spring2008.pdf (describing how domestic violence cases "are rushed

through the system without being given the care and attention that 'equal justice or effective representation' would require").
For a variety of reasons, many domestic violence petitioners do not proceed with their cases. When petitioners fail to appear in court for the hearing for the longer-term protection order, their cases are dismissed. See Laurie S. Kohn, The Justice System and Domestic Violence: Engaging the Case but Divorcing the Victim, 32 N.Y.U. Rev. L. & Soc. Change 191, 205 (2008) (citing high dismissal rates in protection order dockets based on the failure of petitioners to appear in court). Judicial efficiency, then, is one reason for the mass calendar call in domestic violence courts. Any increase in judicial resources, either through adding judges or scheduling cases (despite the high rate of dropped cases), would likely increase the funds devoted to domestic violence cases, but this cost is worthwhile in light of the personal and safety needs that these courts address.

159 See infra Part III.A (describing the many types of cases in which judges close courtrooms to the public). This recommendation would require a judge to hear a litigant's request for a closed courtroom and conduct the necessary balancing test, as described in Part III.A. While acknowledging that greater use of this already-available procedural option would require a judge to conduct a motions hearing prior to closing the courtroom, this process is necessary to ensure that rights are appropriately weighed and that litigants have full access to courts.

160 See Katherine A. Kelly, Comment, The Assumption of Risk Defense and the Sexual Transmission of AIDS: A Proposal for the Application of Comparative Knowledge, 143 U. Pa. L. Rev. 1121, 1133-34 (1995) (recommending anonymous suits to alleviate concerns about publicizing one's HIV status or sexual history in AIDS litigation).

161 See Fed. R. Civ. P. 26(c) (permitting judges to shield information in depositions and discovery where it would cause annoyance, embarrassment, or undue burden or expense).

162 See Kinports & Fischer, supra note 124, at 214 (advocating for a case-by-case determination of whether a protection order case should be heard in a less formal environment). Proceedings should not occur "off the record," as the record is crucial for appeals and as evidence in other cases, such as custody cases or as proof of domestic violence for remedies for battered immigrants. Not all courts keep records of proceedings.

163 See generally Doe v. Se. Pa. Transp. Auth., 72 F.3d 1133 (3d Cir. 1995) (plaintiff alleging that defendant violated his privacy by monitoring the prescription drug program and learning that plaintiff suffered from AIDS); Doe v. City of New York, 15 F.3d 264 (2d Cir. 1994) (plaintiff alleging that defendant violated his privacy by making public a conciliation agreement between the two parties that included plaintiff's HIV-positive status); Doe v. Town of Plymouth, 825 F. Supp. 1102 (D. Mass. 1993) (plaintiff alleging that defendant police officer violated her right to privacy by disclosing her AIDS status to her neighbors); Doe v. City of Cleveland, 788 F. Supp. 979 (N.D. Ohio 1991) (plaintiff alleging that defendant police officer violated his right to privacy by noting "AIDS" on his booking card after arresting him and informing plaintiff's employer of his AIDS status); Doe v. Borough of Barrington, 729 F. Supp. 376 (D.N.J. 1990) (plaintiffs-- mother and children--alleging that defendant police officer violated their right to privacy by disclosing the mother's husband's AIDS status); Doe v. Coughlin, 697 F. Supp. 1234 (N.D.N.Y. 1988) (inmate plaintiffs alleging that defendant violated their right to privacy by confining them to a separate wing in the correctional institution because of their HIV status).

164 Allowing the public and press to attend proceedings reinforces public confidence in the judiciary system, increases judicial accountability, informs society about the nature of problems in a community, informs the public of government operations, allows for the free flow of information, and prevents inconsistent judicial rulings. Particularly in criminal cases, open courts give assurances of fairness to the accused and the public. See, e.g., Mary Flood, Chronicle Asks for Transcript of Conference, Houston Chron., Aug. 2, 2003, at 1C (expressing the public's right to know what occurs in courts).
The Supreme Court of the United States has considered the right of access to trials in a line of cases. See Press-Enterprise Co. v. Superior Court, 478 U.S. 1, 7-13 (1986); Globe Newspaper Co. v. Superior Court, 457 U.S. 596, 603-06, 609-10 (1982); Richmond Newspapers, Inc. v. Virginia, 448 U.S. 555, 565 (1980). While the Supreme Court cases discuss the right of access in criminal proceedings, federal courts have applied the analysis to civil cases. See, e.g., Brown & Williamson Tobacco Corp. v. Fed. Trade Comm'n, 710 F.2d 1165, 1179 (6th Cir. 1983); Binney & Smith Inc. v. Rose Art Indus., No. 94C6882, 1995 U.S. Dist. LEXIS 3151, *4 (N.D. Ill. Mar. 13, 1995).

[165] Press-Enterprise Co. v. Superior Court, 464 U.S. 501, 510 (1984) (requiring the court to articulate findings when making a decision about closure, so that a reviewing court can evaluate the propriety of the closure order).
Based on the standard established by the Supreme Court of the United States, some states have adopted family court rules regarding access to proceedings and listing factors for excluding the public. For example, in New York, family courts are open to the public, but judges have discretion to exclude people from the courtroom on a case-by-case basis. N.Y. Comp. Codes R. & Regs. tit. 22, § 205.4 (2008). Factors for exclusion include the objection of any party based on compelling reasons, the nature of the proceeding, privacy interests of litigants, the need for protection of the litigants, and the unavailability or inappropriateness of less restrictive alternatives. Id. Explicit inclusion of such a procedural rule in domestic violence court rules could help guide litigants, attorneys, and judges.

[166] See, e.g., N.Y. Pub. Health Law §§ 2785(3), (6)(b) (McKinney 2007) (establishing mechanisms for court authorization of the disclosure of HIV status in situations of imminent danger and prohibiting the person or organization to whom this information is disclosed from re-disclosing the information to anyone else). This may occur only after an in camera hearing where documents are sealed, and any pleadings and court orders cannot use the name of the individual whose information is sought. Id.; Bragdon v. Abbott, 524 U.S. 624, 637 (1998) (finding that HIV-positive individuals are protected under the Americans with Disabilities Act). See generally Doughty, supra note 38, at 140-41 (discussing the numerous confidentiality protections for HIV and AIDS status in constitutional and common law rights, statutory protection for HIV-specific information, and statutory protection for medical information). The analysis in this Article focuses on constitutional law because it is more immutable and has more permanent implications.

[167] Doe v. City of New York, 15 F.3d 264, 267 (2d Cir. 1994) (citing Whalen v. Roe, 429 U.S. 589, 599 (1977), which recognized a constitutional right to privacy that protects "the individual interest in avoiding disclosure of personal matters," and stating that the "[e]xtension of the right to confidentiality to personal medical information recognizes there are few matters that are quite so personal as the status of one's health, and few matters the dissemination of which one would prefer to maintain greater control over"); see also Yoder v. Ingersoll-Rand Co., No. 97-3710, 1998 U.S. App. LEXIS 31993, at *6 (6th Cir. Dec. 22, 1998) (finding that the plaintiff's AIDS status was "a clearly private fact"); Hillman v. Columbia County, 474 N.W.2d 913, 922 (Wis. Ct. App. 1991) (discussing the Fourteenth Amendment protection and finding a constitutional right to privacy in one's HIV status, determining that this is a private fact).

[168] Whalen, 429 U.S. at 606.

[169] See supra note 167 and cases cited therein.

[170] See Multimedia WMAZ, Inc. v. Kubach, 443 S.E.2d 491, 495 (Ga. Ct. App. 1994) ("Unlike the identities of those involved in crimes, the identities of those suffering from AIDS are generally not a matter of public interest, as our legislature has recognized."). The court then cites state law that places restrictions on disclosure of "AIDS confidential information" and makes it a misdemeanor to violate those restrictions. Id.

[171] See supra Part II.B.1.

[172] See, e.g., Kohn, supra note 53, at 45-49 (discussing the state interest of protecting individuals from domestic violence); Phillip F. Schuster, II, Constitutional and Family Law Implications of the Sleeper and Troxel Cases: A Denouement for Oregon's Psychological Parent Statute?, 36 Willamette L. Rev. 549, 666 n.382 (2000) (explaining that courts are permitted to enter temporary ex parte custody orders because of the overriding state interest of protecting spouses and children from domestic violence).
Federal and state laws provide a range of protections explicitly for survivors of domestic violence. The Violence Against Women Act of 1994 (with subsequent amendments) and federal legislation comprehensively addressing domestic violence created new protections for victims of domestic violence; funded a national domestic violence hotline; defined new crimes; created grants for programs to prevent and respond to domestic violence, sexual assault, and stalking; and provided new immigration remedies to permit battered immigrants to apply for permanent residency without relying on an abusive spouse. See, e.g., Violence Against Women Act of 1994, Pub. L. No. 103-322, 10 Stat. 1902 (codified as amended in scattered sections of 42 U.S.C. and 28 U.S.C.); Violence Against Women

Act of 2000, Pub. L. No. 106-386, 114 Stat. 1491 (codified as amended in scattered sections of 42 U.S.C.); Violence Against Women and Department of Justice Reauthorization Act of 2005, Pub. L. No. 109-162, 119 Stat. 2960 (codified as amended in scattered sections of 42 U.S.C.). For similar state protections, see also Cal. Health & Safety Code § 34328.1 (2008) (restricting the ability of public housing authorities to terminate the tenancies of victims of domestic violence); Colo. Rev. Stat. Ann. § 13-40-107.5 (2008) (providing a defense against eviction to domestic violence survivors); D.C. Code § 16-914 (2009) (requiring courts determining child custody to consider domestic violence and creating a rebuttable presumption that joint custody is not in a child's best interest when one parent has committed an intrafamily offense); R.I. Gen. Laws § 12-28-10 (2009) (prohibiting an employer from discriminating against someone because he or she seeks a domestic violence protection order or refuses to seek such an order); Wash. Rev. Code § 59.18.352 (2008) (requiring landlords to permit victims of domestic violence to be released from rental agreements).

173 Press-Enterprise Co. v. Super. Ct., 478 U.S. 1, 9 n.2 (1986) (citing Globe Newspaper Co. v. Super. Ct., 457 U.S. 596, 607-10 (1982)).

174 See 2 Karen Moulding, Nat'l Lawyers Guild, Sexual Orientation and the Law § 15:5 (Roberta Achtenberg ed., 2008) (recommending filing cases using a pseudonym or "Doe" as opposed to initials, seeking a protective order concerning the client's identity, limiting discovery to prevent public disclosure of a litigant's identity, and sealing cases); see also John C. v. Martha A., 592 N.Y.S.2d 229, 235 (N.Y. City Ct. 1992) (sealing the court file in a landlord/tenant case because information about the defendant's HIV status appeared throughout the record). The court determined that the
fundamental privacy interests and the statutory confidentiality respecting HIV records far outweigh any general predisposition against sealing. In light of the unique nature of this case, it would be futile to remove and seal only the medical records, and impracticable to redact all the other impermissible references. The entire court file is permeated with confidential and embarrassing information. To permit any part of this file to remain open to public inspection would disclose respondents' identities and subvert the purpose of the confidentiality statute.
John C., 592 N.Y.S.2d at 235.

175 See, e.g., D.C. Code § 16-2316(e)(2) (2001) (excluding the public from juvenile proceedings, including child abuse and neglect, delinquency, and person in need of supervision cases); Minn. Stat. § 260C.163(1)(c) (2007) (noting that juvenile cases, including civil actions involving cases of abuse, neglect, truancy, runaway, termination of parental rights, and permanency cases, are confidential and closed to the public, with the exception of judges using their discretion to permit admission of individuals who have a "direct interest in the case or in the work of the court"). Statutes often provide for judges to allow others, including the press, to be admitted if they have a "proper interest in the case or the work of the court on condition that they refrain from divulging information identifying the child or members of the child's family involved in the proceedings." D.C. Code § 16-2316(e)(3).

176 See, e.g., D.C. Code § 16-311; Idaho Code Ann. § 16-1511 (2008).

177 See Ann Crawford McClure, Richard Orsinger & Robert H. Pemberton, A Guide to Proceedings Under the Texas Parental Notification Statute and Rules, 41 S. Tex. L. Rev. 755, 834 (2000). In judicial bypass proceedings for minors seeking abortions, there are statutory confidentiality and anonymity requirements, including requirements that hearings be held in a location that protects confidentiality, such as a judge's chambers or jury room. Id.

178 See, e.g., Ben Fidler, Granite, Rivals to Present Plan Changes, Daily Deal, Apr. 26, 2007.

179 Frederick J. Tansill, Asset Protection Trusts (APTs): Non-Tax Issues, in ALI-ABA Course of Study: International Trust and Estate Planning 369, 519 (2006) (describing the confidentiality of trusts, criminal penalties for disclosing information, in-chambers review of documents and hearings, and additional measures to safeguard information).

180 See, e.g., Intel Asks Court to Block Rival, N.Y. Times, Sept. 13, 1991, at D3 (explaining that much of the hearing was conducted in closed court because of the proprietary nature).

[181] See, e.g., Gay Elwell, E. Allen Firm Wins Trade-Secret Injunction, Morning Call (Allentown, P.A.), May 8, 1992, at B7 ("Given the sensitive nature of the case, some testimony was given in closed court sessions and particularly sensitive information is included in an unpublished confidential appendix to the ruling.").

[182] See, e.g., Glenn F. Bunting, Much of "Sahara" Trial Held Behind Closed Doors, L.A. Times, May 1, 2007, at 1 (citing the problem of trying a case in the press); Jackson Lawyers Seek Closed Hearings, Chi. Trib., Jan. 8, 2005, at 12 (seeking a closed courtroom in Michael Jackson's child molestation case); Judge Closes Court, Opens Jury Talks: Ito's Move May Be an Attempt to Relieve Some of the Tensions of the Jury's Sequestration, Orlando Sentinel, Apr. 20, 1995, at A7 (discussing a closed hearing regarding sequestration of the jury in the O.J. Simpson criminal trial).

[183] Bunting, supra note 182.

[184] See, e.g., Jesse Drucker, Wal-Mart Asks North Carolina Court to Seal Documents in Tax-Dispute Case, Wall St. J., Nov. 1, 2007, at A4.

[185] See Steve McGonigle, Secret Lawsuits Shelter Wealthy, Influential: Practice Pits Right to Privacy Against Public's Right to Know, Dallas Morning News, Nov. 22, 1987, at 1A (reporting that, in an investigation of sealed cases in Dallas, Texas, most cases were sealed to prevent embarrassment or to protect companies, and some of the sealed lawsuits contained allegations of sexual misconduct by doctors, professional incompetence, fatally defective products, environmental contamination, and loan defaults by executives). Court files are often sealed in lawsuits involving wealthy litigants, large corporations, and powerful financial institutions, and may be sealed as part of a settlement agreement in return for confidentiality. Id.

[186] Philip Trompeter, Gender Bias Task Force: Comments on Family Law Issues, 58 Wash. & Lee L. Rev. 1089, 1094 (2001). This statement was a reflection on testimony at public hearings as part of the task force's data collection. The sentiment applies to open court proceedings as well.

[187] Across jurisdictions, the majority of litigants in domestic violence and family law cases are pro se, and these numbers are increasing. See, e.g., Balos, supra note 130, at 567 (reporting that, in one Illinois jurisdiction, neither party was represented in 83.4% of civil protection cases); Margaret Martin Barry, Accessing Justice: Are Pro Se Clinics a Reasonable Response to the Lack of Pro Bono Legal Services and Should Law School Clinics Conduct Them?, 67 Fordham L. Rev. 1879, 1913 (1999) (stating that, in the District of Columbia, domestic violence litigants are pro se in seventy-four percent of the cases (citing D.C. Task Force on Fam. L. Representation, D.C. Bar Pub. Servs. Activities Corp., Access to Family Law Representation in the District of Columbia 40 (1992))); Buel, supra note 131, at 722 (finding that, for decades, "there has existed a crisis in the dearth of legal representation available for battered women"); Drew A. Swank, In Defense of Rules and Roles: The Need to Curb Extreme Forms of Pro Se Assistance and Accommodation in Litigation, 54 Am. U. L. Rev. 1537, 1539-41 (2005) (comparing the number of pro se litigants in all civil cases to statistics on pro se domestic violence litigants, concluding that family court cases have experienced the largest increase, and noting that, even in federal cases, approximately one-quarter of all federal civil cases are filed by pro se litigants in the United States); Merle H. Weiner, Domestic Violence and Custody: Importing the American Law Institute's Principles of the Law of Family Dissolution into Oregon Law, 35 Willamette L. Rev. 643, 687 (1999) (stating that, in Oregon, at least one party is unrepresented in approximately eighty percent of family law cases (citing Oregon Task Force on Family Law, Final Report to Governor John A. Kitzhaber and the Oregon Legislative Assembly, Creating a New Family Conflict Resolutions System 5 (Dec. 31, 1997))).

[188] Balos, supra note 130, at 568-69. Some domestic violence survivors are unable to seek protection orders because of the number and complexity of the forms required. Approximately fifty percent of attorneys surveyed in a study on protection orders responded that the complexity or volume of paperwork prevents abuse survivors from filing petitions for orders of protection in their jurisdiction. Kinports & Fischer, supra note 124, at 171, 175. While many jurisdictions have developed forms and practices that theoretically make the system more conducive to being pro se, these simplified forms are still too complex for many petitioners. Id. at 171. Many pro se petitioners will not recognize what is legally relevant and may not raise crucial information that an attorney would elicit.

189 In 1963, the Supreme Court of the United States ruled in Gideon v. Wainwright that individuals are entitled to counsel in criminal cases. 372 U.S. 335, 345 (1963). There is growing support for a "civil Gideon," which calls for the right to counsel for civil litigants, particularly in cases where low-income individuals face a basic human need, such as the loss of food, shelter, safety, health, or the custody of a child. See Balos, supra note 130, at 557 (arguing that victims of domestic violence have a right to appointed counsel under the due process clause of the Fourteenth Amendment); Russell Engler, Shaping a Context-Based Civil Gideon from the Dynamics of Social Change, 15 Temp. Pol. & Civ. Rts. L. Rev. 697, 712 (2006) (advocating that the case for "civil Gideon" is strengthened by using the example of the power imbalances in domestic violence cases); William H. Neukom, An Investment in Our Future: Adequate Legal Services Corp. Funding Will Alleviate Poverty-Related Problems, 94 A.B.A. J. 9, 9 (April 2008) (describing how, in 2006, the American Bar Association adopted a "civil Gideon" policy supporting a right to counsel in civil cases where basic human needs are at stake). Recognizing a right to counsel in civil cases would naturally require tremendous resources, and public defender offices already suffer from underfunding and staffing. "Civil Gideon" would also require the reversal of Lassiter v. Department of Social Services, 452 U.S. 18 (1981), in which the Court ruled (5-4) that the Constitution does not guarantee a right to counsel in civil cases.

190 Ethical rules prevent clerks from giving legal advice, and clerks may misinterpret these rules and refuse to provide even basic information about the process. See, e.g., Model Rules of Prof'l Conduct R. 5.5 (2008) (prohibiting the unauthorized practice of law). With the unavailability of assistance with the initial step of filing a petition and too few advocates to assist each petitioner, the survivor lacks guidance to take additional legal steps to protect the privacy of sensitive information and omits this information altogether. See Barry, supra note 187, at 1913 n.221 ("The lack of a clear interpretation of the proscription against giving legal advice leads to inconsistent application. Thus, personal preference enters the equation, with the person favored by a given clerk receiving more information--and even receiving advice--than the person who is not as convivial.").
When seeking a protection order, clerks may be misinformed, not able to help, or a hindrance to filing a case. Some clerks evaluate the merits of a claim and refuse to accept a petition before the case is even seen by a judge. Kinports & Fischer, supra note 124, at 173, 177.

191 See, e.g., Mahoney, supra note 2, at 1 (portraying the stories of ordinary women who experienced violence in their intimate relationships).

192 Apel, supra note 38, at 19 ("The authors of [a study on partner response to HIV disclosure] acknowledge that many negative reactions to HIV disclosures may be predicated on public ignorance, and hiding HIV status may only contribute to that ignorance. Nevertheless, as the authors conclude, 'the burden of educating "the public" ... should not fall to the women themselves."' (quoting Gielen et al., supra note 37, at 30)).

193 States and courts long refused to intervene in domestic violence, and there are many recent accounts of judges making inappropriate comments, mistreating women who have experienced abuse, and failing to award protection orders and statutory remedies when litigants meet the requirements for receiving such orders. See Kinports & Fischer, supra note 124, at 207-08 (reporting survey results that judges are often disrespectful and insensitive to petitioners, they do not take domestic violence and protection order requests seriously, they fail to convey that abusive behavior is unacceptable and illegal, and that victims of domestic violence are often dissuaded from seeking protection from the court after being humiliated, ridiculed, and embarrassed by judges). In the survey, 55.4% of respondents reported that the judges in their area express impatience and are insensitive when women are emotional or confused when testifying, and 55.7% of respondents reported victim-blaming statements by judges during protection order hearings. Id. The numerous examples of judicial mishandling of intimate partner violence include examples of the failure to issue a protection order or the release of a defendant with an extensive history of high-level violence leading to homicide. See, e.g., Lisa Memoli & Gina Plotino, Enforcement or Pretense: The Courts and the Domestic Violence Act, 15 Women's Rts. L. Rep. 39, 39-40, 44-46 (1993) (describing examples of husbands who killed their wives after judges failed to take appropriate action). The following examples are offered to show the extent of judicial mishandling and how closing domestic violence courtrooms and limiting monitoring abilities is dangerous. Thirty-nine states have now convened task forces on gender bias in the courts, and the task forces report widespread gender bias, particularly against battered women. The resulting reports rely heavily on narratives and contain copious accounts of judges trivializing violence against women. See Goodmark, supra note 143, at 745. For example, in testimony before Missouri's task force, the director of the Missouri Coalition Against Domestic Violence reported on the frequency of inappropriate comments and belittling behavior by judges. Another witness testifying before Missouri's task force reported that one judge asked women if they liked being beaten. Lynn Hecht Schafran, There's No Accounting for Judges, 58 Alb. L. Rev. 1063, 1065 (1995) (citing Executive Council Mo. Jud. Conf., Report of the Missouri Task Force on Gender and Justice 37 (1993)). The report of one Florida judge's cruel

and inappropriate behavior is frequently cited as an example of judges mishandling and trivializing violence against women. After hearing that the defendant "doused his wife with lighter fluid and set her on fire," the judge sang "you light up my wife" to the melody of "You Light Up My Life." Id. at 1065 (citing Fla. Sup. Ct., Report of the Florida Supreme Court Gender Bias Study Commission 121 (1990)). A Colorado judge gave a minimal weekend sentence to a man who murdered his wife when she attempted to leave their abusive marriage. The judge said that the deceased provoked her husband by not telling him that she was leaving. Id. at 1066 (citing Judge Upheld on Remark About Slain Woman, N.Y. Times, July 17, 1984, at A22). A Maryland judge, while denying a petition for a protective order, explained his reasons for not believing a woman's testimony that her husband threatened her with a gun. The judge remarked, "I don't believe anything that you're saying.... The reason I don't believe it is because I don't believe that anything like this could happen to me.... Therefore, since I would not let that happen to me, I can't believe that it happened to you." Goodmark, supra note 143, at 747 (citing Md. Special Joint Comm. on Gender Bias in Cts., Gender Bias in the Courts 2-3 (1989)).

194 Court watch programs have been created in many jurisdictions to track compliance with protection order laws, monitor whether judges and prosecutors are treating protection order violations seriously, document judges' treatment of litigants, motivate judges to correct inappropriate behaviors, and improve the legal response. When programs issue reports or share their data, they increase public participation and understanding, and may cause judges to recognize their own problematic behavior and make future changes. Such accountability mechanisms are important to creating a responsive system that does not endanger victims. See generally Bergen County Comm'n on the Status of Women, Community Court Watch II: A Study of Bergen County Family Court System and the Enforcement of the State of New Jersey Prevention of Domestic Violence Act, 17 Women's Rts. L. Rep. 79, 82 (1995) (describing the Community Court Watch Project as an "instrument of change" to positively affect the handling of domestic violence cases); Sarah M. Buel, Family Violence: Court Watches: Improving Services to Victims by Documenting Practices, Tex. Prosecutor, July-Aug. 1999, at 16, 18-19 (describing court monitoring programs and their successful use around the country); Memoli & Plotino, supra note 189, at 47 n.105 (identifying the Cook County court watching program as the oldest citizen-watching program of its kind).

195 See supra text accompanying note 5.

196 See supra text accompanying note 43.

197 See supra text accompanying note 62.

198 Murphy, supra note 97, at 1246 (citing Minow, supra note 153, at 1688); see also Toni M. Massaro, Empathy, Legal Storytelling, and the Rule of Law: New Words, Old Wounds?, 87 Mich. L. Rev. 2099, 2105 (1989) ("[A] concrete story comes closest to actual experience and so may evoke our empathic distress response more readily than abstract theory. Telling stories can move us to care, and hence pave the way to action.").

199 See Murphy, supra note 97, at 1247 (recounting that, in the process of developing the legal response to domestic violence, it was recognized that the legal system's historical inability to respond to partner violence was related to male decisionmakers' difficulty understanding the issues, and concluding that legal storytelling was key to creating empathic understanding that enabled meaningful reform).

200 A large body of narrative legal scholarship stresses how "narratives bring the voices of those traditionally deprived of power within the legal system to the forefront." Goodmark, supra note 143, at 732. Offering stories that are an alternative to the mainstream voice raises consciousness, illustrates the ways in which the law excludes these previously silenced voices, and shows the need for the law to be reformed to include the "outsider" voice. See Delgado, supra note 140, at 2412 (describing "outgroups" as "groups whose marginality defines the boundaries of the mainstream, whose voice and perspective--whose consciousness--has been suppressed, devalued, and abnormalized," and arguing that telling stories is a way to "create their own bonds, represent cohesion, shared understandings, and meanings.... An outgroup creates its own stories, which circulate within the group as a kind of counter-reality."); Murphy, supra note 97, at 1252 (discussing the call for those in "outgroups" to tell their stories to prompt reform); Sheppard & Westphal, supra note 5, at 345 ("Outsider narratives contest the structures of inequality and oppression by raising consciousness and convictions about the possibility for change. The very process of

breaking silences, of 'coming to voice,' attests to the reality of resistance in the face of often grinding and relentless social constraints.").

201 See Murphy, supra note 97, at 1253 (arguing for more explicit use of narratives to highlight the human dimension of those who have been historically unrepresented). Storytelling has been successfully used to reform domestic violence laws, and there are now multiple examples in the domestic violence context of how using powerful human stories can bring about social change in the legal system. Murphy promotes storytelling as a key element in social change strategy and credits the power of direct stories with achieving law reform in Maryland. Id. at 1274-75. Through a strategy of having victims tell their individual stories, Maryland advocates and survivors were able to change laws that prohibited battered women who killed their abusers from telling their stories in court, to persuade the governor to commute the sentences of eight women imprisoned for killing or attempting to kill their abusers, and to reform Maryland's civil protection order law. Id. at 1274-90. The power of individuals' stories far outweighed advocacy efforts of judges, lawyers, and court personnel. In one example, Murphy describes the testimony to the legislature of three women who were seriously injured as a result of inadequacies in the protection order law, and how their stories describing the pain they suffered far overpowered the response of more paperwork for judges and clerks. Id. at 1290-91. These direct stories, putting a face and voice on the victims, proved much more effective than statistics and theoretical arguments. The legislators were unable to distance themselves from these women telling their stories, and the direct testimony had a transformative effect in changing the laws. These examples demonstrate how individual stories have the power to act as change agents in prompting reform. Id. at 1273-75, 1292-93 ("Legal storytelling--stories told to legal decisionmakers about the pain that results from inadequate laws--must be an integral part of law reform work."). Murphy also notes:

Ultimately, this is a story about domestic violence victims and their advocates, who forced decision-makers to listen after decades of inattention to the problem. They listened, not only to the experts, and not only to the statistical and fiscal impact testimony--they listened to the stories of the women and children who have been devastated by the legal system's historical tolerance of violence in the home.

Id.

202 Id. at 1253; see also Delgado, supra note 140, at 2414 ("[S]tories can shatter complacency and challenge the status quo."); Phyllis Goldfarb, A Theory-Practice Spiral: The Ethics of Feminism and Clinical Education, 75 Minn. L. Rev. 1599, 1632-33 (1991) (explaining that decisionmakers who hear enough detail to imagine a vicarious experience are able to connect to experiences outside of their own in a way that awakens empathy and makes action imperative); John B. Mitchell, Narrative and Client-Centered Representation: What Is a True Believer to Do When His Two Favorite Theories Collide?, 6 Clinical L. Rev. 85, 95-96 (1999) ("Stories make us understand the world of others, those seemingly like us as well as those seemingly different.").

203 The judiciary is a legitimizing force, with its ruling ordering society, and it has an instrumental role in continuing silence or creating change. Domestic violence and family court judges "must take seriously the obligation to write the stories of domestic violence; to create the canons and precedents that are specifically tailored to this area." Fenton, supra note 139, at 1059 (describing the power of the judiciary as having the authority to "use story as a means of re-creating norms, to alter our concept of violence in society, and to affect the power structure that permits and conditions private violence").

204 Id. at 1000-01.

205 Id. (arguing that, when a situation "poorly fits the paradigm underlying an existing rule of law, the ill-fit ought to be elaborated so that appropriate new law can be developed").

206 Id.

207 See Murphy, supra note 97, at 1252; see also Mitchell, supra note 22, at 96 n.47 (citing the century-long feminist claim that "distinctive aspects of women's experiences and perspectives offer resources for constructing more representative, more empathic, more creative, and, in general, better theories, laws, and social practices").

208 Herman, supra note 100, at 72 ("The contradictions between women's reality and the legal definitions of that same

reality are often so extreme that they effectively bar women from participation in the formal structures of justice.").

209 See, e.g., D.C. Code § 16-1005(c) (2001) ("If, after hearing, the Family Division finds that there is good cause to believe the respondent has committed or is threatening an intrafamily offense ... it may issue a protection order."). D.C. Code § 16-1001(6) defines "intrafamily offense" as

> an act punishable as a criminal offense committed by an offender upon a person to whom the offender is related by blood, legal custody, marriage, domestic partnership, having a child in common, or with whom the offender shares or has shared a mutual residence; or with whom the offender maintains or maintained a romantic relationship not necessarily including a sexual relationship ....

Id.

Notably, in the District of Columbia, a temporary protection order may be issued if the "safety or welfare of a family member is immediately endangered by the respondent." D.C. Code § 16-1004(d)(1). The finding of a criminal offense is not required. Id.

210 Government agencies, advocates, and educators commonly use this definition and the Duluth Model's Power and Control Wheel to explain domestic violence. For example, on the Washington, D.C., government website, the Metropolitan Police Department has a section dedicated to describing domestic violence that recites this definition. Metro. Police Dep't, What Is Domestic Violence?, http://mpdc.dc.gov/mpdc/cwp/view,a,1232,q,541187.asp (last visited Apr. 8, 2009). The website further explains that, in addition to the threat or actual use of violence,

> domestic violence can include emotional abuse, such as name-calling and put-downs, and economic abuse, when one person uses money and finances to control the other. Often an abusive partner may be sexually abusive, use or control the children, or threaten, isolate, or intimidate the other. All of these behaviors are used to maintain fear, intimidation and power. Although not all of these behaviors are against the law (such as in cases of emotional abuse without physical harm), none of them are acceptable ....

Id.

A similarly expansive definition of domestic violence is found in immigration law. An immigrant who self-petitions for an adjustment of immigration status under the Violence Against Women Act, rather than relying on the sponsorship of an abusive spouse, must prove that he or she has experienced domestic violence. See 8 C.F.R. § 204.2(c)(1)(vi) (2008) (qualifying domestic abuse as including physical abuse, threats, psychological abuse, and "[o]ther abusive actions ... under certain circumstances, including acts that, in and of themselves, may not initially appear violent but that are a part of an overall pattern of violence").

211 For example, Mississippi's statute exclusively considers physical harm or threats of imminent harm. To seek a protection order, a person must file a petition "alleging abuse by the respondent." Miss. Code Ann. § 93-21-7(1) (2008). "Abuse" is defined in Miss. Code Ann. § 93-21-3(a)(i)-(vi) as attempting or causing bodily injury, placing another "in fear of imminent serious bodily injury," criminal sexual conduct against a minor, stalking, cyberstalking, or certain sexual offenses. Florida's statute focuses on physical and sexual assault in defining "domestic violence." "'Domestic violence' means any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member." Fla. Stat. § 741.28(2) (2008). Virginia's domestic violence statute also addresses only physical violence, and defines "family abuse" as "any act involving violence, force, or threat including, but not limited to, any forceful detention, which results in bodily injury or places one in reasonable apprehension of bodily injury and which is committed by a person against such person's family or household member." Va. Code Ann. § 16.1-228 (2008).

212 Researchers have found that psychological violence is associated with many of the same negative health outcomes as physical violence in intimate partner relationships. Ann L. Coker et al., Physical Health Consequences of Physical and Psychological Intimate Partner Violence, 9 Arch. Fam. Med. 451, 456 (2000).

213 This Article intentionally focuses on civil orders, injunctive relief, and survivor-centered remedies, and does not address criminal prosecutions that could currently or potentially arise out of HIV-related violence. Aggressive prosecution policies that do not account for the survivor's own safety assessment and the risk of future harm could place domestic violence survivors in greater danger. Epstein et al., supra note 133, at 466-70, 486 (explaining the potential for escalated severity and frequency of abuse following domestic violence prosecutions, and the need for an alternative to the current no-drop prosecution model).

[214] See Mo. Rev. Stat. § 455.010(1)(c) (2008) (identifying coercion as a legally recognizable form of abuse, and defining coercion as "compelling another by force or threat of force to engage in conduct from which the latter has a right to abstain or to abstain from conduct in which the person has a right to engage").

[215] In Mississippi, "[a]ny person who willfully, maliciously and repeatedly follows or harasses another person, or who makes a credible threat, with the intent to place that person in reasonable fear of death or great bodily injury is guilty of the crime of stalking." Miss. Code Ann. § 97-3-107(1). In Missouri, the stalking action must result in alarm to the petitioner, and "alarm" is defined as "fear of danger of physical harm." Mo. Rev. Stat. § 455.010(10)(c).

[216] Creating new grounds for petitioning for orders of protection, such as the proposed grounds of medical interference, could mean that more litigants would bring claims and that courts would experience a higher volume of cases. Considering the health and safety implications of the use of HIV infection in domestic violence, the consequence of additional claims would be worth the cost.

[217] See supra notes 60-63 and accompanying text.

[218] See supra notes 58-59 and accompanying text.

[219] The situation of HIV-related violence has garnered little response, is highly stigmatized, and needs further development, as this Article advocates. The failure to respond has particularly acute health implications. This is not, however, the only complexity in survivors' lives, and domestic violence response systems also need to respond to a range of multiple intersections. Other issues include language, immigration status, geographic proximity to services, disability, and resource deprivation for low-income survivors. See, e.g., Kimberle Crenshaw, Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color, 43 Stan. L. Rev. 1241, 1242 (1991) (explaining that women's experiences of violence are often shaped by multiple dimensions of their identities, including race and class); Lemon, supra note 1, at 38 (emphasizing the importance of domestic violence courts providing free professional interpreters); Shelby A.D. Moore, Understanding the Connection Between Domestic Violence, Crime, and Poverty: How Welfare Reform May Keep Battered Women from Leaving Abusive Relationships, 12 Tex. J. Women & L. 451, 456 (2003) (describing the connections between the abuse that women suffer and the crimes they commit and examining the economic barriers to escaping abuse, including the "systemic impediments" created through welfare reform); Deborah A. Morgan, Access Denied: Barriers to Remedies Under the Violence Against Women Act for Limited English Proficient Battered Immigrant Women, 54 Am. U. L. Rev. 485, 509 (2004) (arguing that U.S. Citizenship and Immigration Services' administration of the Violence Against Women Act violates the due process rights of immigrant survivors of abuse); Lisa R. Pruitt, Toward a Feminist Theory of the Rural, 2007 Utah L. Rev. 421, 444 (2007) (discussing rural women's increased vulnerability and limited access to support and intervention services); Karen Nutter, Note, Domestic Violence in the Lives of Women with Disabilities: No (Accessible) Shelter from the Storm, 13 S. Cal. Rev. L. & Women's Stud. 329, 331 (2004) (explaining how civil protection orders and abuse shelters do not adequately serve the needs of survivors with disabilities).

[220] The Violence Against Women Act provides funding for judicial training. 42 U.S.C. § 13992 (2006). Training for judges hearing domestic violence matters is widely recommended and occurs in many jurisdictions. See Deborah Epstein, Effective Intervention in Domestic Violence Cases: Rethinking the Roles of Prosecutors, Judges, and the Court System, 11 Yale J.L. & Feminism 3, 44 n.234 (1999) (finding that "[v]irtually every study of court response to domestic violence has recommended judicial training as a necessary remedy to existing systemic problems," and reporting positive effects of initial trainings); Klein & Orloff, supra note 24, at 811-12 (reporting on the National Institute of Justice finding of the importance of judicial training in teaching judges about the dynamics and complexities of domestic violence, and how training causes judges to treat family violence as a violent crime); see, e.g., Cal. Gov't Code § 68555 (West 2008) (requiring a domestic violence session as part of the orientation and annual training program for judges hearing domestic violence matters). But cf. Leigh Goodmark, Law Is the Answer? Do We Know That for Sure?: Questioning the Efficacy of Legal Interventions for Battered Women, 23 St. Louis U. Pub. L. Rev. 7, 19 (2004) (arguing that no amount of judicial training can remedy the fact that the legal system is not helpful to some battered women, and may actually be harmful). There is consensus among advocates that training is most effective for judges who are receptive to learning about domestic violence; however, the true effectiveness of judicial training programs has not been measured.

[221] Remedies commonly awarded in protection orders include requirements that the abusive party refrain from assaulting, threatening, contacting, or going near the petitioner; vacate a shared residence; enter counseling; and pay attorney's fees, medical expenses, or maintenance. Judges may also award custody, visitation, and child support. See, e.g., D.C. Code § 16-1005 (2001). In the District of Columbia, judges may also order the respondent "to perform or refrain from other actions as may be appropriate to the effective resolution of the matter." D.C. Code § 16-1005(c)(10); see also Kohn, supra note 53, at 9 (identifying forty states' civil domestic violence laws with catch-all provisions that allow judges to create tailored remedies).

[222] See Kohn, supra note 53, at 25 (examining the constitutionality of speech restrictions that may be included in protection orders to prohibit an abusive partner from telling a petitioner's employer, neighbors, or children's schools about the petitioner's health status or sexual orientation, and otherwise limiting the ability to reveal particular information).

[223] For a more thorough discussion of the effectiveness of civil protection orders, see sources cited supra note 108.

[224] Recognizing that legal representation makes a difference in combating domestic violence, Congress is currently considering legislation that would authorize the American Bar Association to create a nationwide network of volunteer attorneys to represent survivors of intimate partner violence. The network would initially begin in five states. National Domestic Violence Volunteer Attorney Network Act, S. 1515, 110th Cong. (2007); H.R. 6088, 110th Cong. (2008).

[225] See Klein & Orloff, supra note 24, at 813 (reporting findings of the National Institute of Justice Civil Protection Order study).

[226] The lawyer's own life experiences, biases, and knowledge of universalized legal narratives affect how the lawyer hears the client's story. See, e.g., Binny Miller, Give Them Back Their Lives: Recognizing Client Narrative in Case Theory, 93 Mich. L. Rev. 485, 490 (1994) ("[O]ur own experiences as lawyers shape--for better or worse--the stories that we perceive and elicit from our clients.").

[227] If a lawyer does not approach an initial interview open to really hearing the client, the lawyer may stifle communication, prevent the client from revealing key information, and misinterpret the client's meaning. Clients respond to cues and questions from lawyers, and a lawyer's prepackaged story could displace a client's narrative and silence this client's voice. Anthony V. Alfieri, Reconstructive Poverty Law Practice: Learning Lessons of Client Narrative, 100 Yale L.J. 2107, 2112 (1991) (recalling how a client "learned to keep her answers short" after being interrupted when she tried to expand her answers); see also Gilkerson, supra note 96, at 895, 906 (describing a legal aid intake process during which the potential client has little opportunity to respond or to expand on answers to a pre-established set of questions; explaining that a client's failure to give the "right" answers or her insistence on veering from the established question-and-answer pattern and attempting to tell her story may result in being denied representation; and recommending that, to "discover client narrative voice[,] ... the client must be given room to speak out in the lawyer's office," and "the lawyer must assume a nontraditional interpretive stance, one grounded in client context and perspective, rather than in lawyer pre-understanding").

[228] Alfieri, supra note 227, at 2123-24 (explaining that the practice of fitting a client's story into a set pattern could be a way of attempting to serve a client's end goals by fitting a client's experiences into a narrative that resonates with dominant values and is already accepted by decisionmakers); Gilkerson, supra note 96, at 902-05, 911-12. "Except for the immediate events leading up to the client's legal problem, the lawyer typically does not inquire about the client's life and history.... As a result, the poverty lawyer may not comprehend the relevance of the narratives that compose the stories of poor clients' lives." Gilkerson, supra note 96, at 894.
Lawyers can employ certain practices to present the client's actual experience. Rather than suppressing alternative stories and a client's voice, it is possible to advocate outside of the "stock stories" by ensuring that the client testifies in her own voice, and by explaining how the universalized narrative is not an accurate fit. Id. at 915. Believing that restoring integrity to clients' voices and stories can create change, Alfieri recommends a collaborative approach where "[t]he mutuality of collaboration permits the lawyer to appreciate the diversity of client narratives, forestalling reliance on a generalized lawyer narrative that is incomplete." Alfieri, supra note 227, at 2140-41.

229 See Miller, supra note 226, at 503.

230 For a detailed explanation of client-centered lawyering, see Miller, supra note 226, at 503 (explaining that the lawyer and client jointly consider the available options, the likely consequences, and the advantages and disadvantages of each option in making a decision). See generally David A. Binder et al., Lawyers as Counselors: A Client-Centered Approach (2d ed. 2004) (detailing the client-centered method of legal counseling). The central idea is that clients should have the choice of what to argue, who will testify, and whether they desire to be heard in court. Clients may wish to use a case theory that does not make for the easiest legal case, or the client may make other decisions about how to proceed that render the case almost impossible to "win," but there are multiple issues at play in these decisions. The client may not want to involve a particular witness, may be overwhelmed with the stress of testifying, or may be more concerned about the effect of testifying on an individual's personal life, making such case decisions even if these choices may cause the client to lose the case. Miller, supra note 226, at 508. Clients may have personal reasons for their decisions, because "speaking out, if for no other reason than to have a voice, can be as strategic as intricately plotting testimony to dovetail with relevant legal categories or remaining silent to keep a part of the story secret." Id. at 524.

231 The choice of which story to tell can and should belong to the client. See generally Lucie E. White, Subordination, Rhetorical Survival Skills, and Sunday Shoes: Notes on the Hearing of Mrs. G., 38 Buff. L. Rev. 1 (1990) (exploring how race and class differences interfered with the attorney's ability to create a case theory the client was comfortable with, and the resulting differences between the story the attorney anticipated telling and the testimony the client gave).

232 See Sarah M. Buel, Effective Assistance of Counsel for Battered Women Defendants: A Normative Construct, 26 Harv. Women's L.J. 217, 226 (2003) ("[An abuse victim] who has often been denied even the right to speak by the abuser, needs her lawyer to accurately present her voice in court. Counsel should encourage a battered client to find her voice and center case strategies upon it.").

233 For example, one client's husband became physically abusive after he contracted AIDS, and his health declined while she remained healthy. This client rejected a case theory that involved this explanation for the violence, and she opposed any mention of health.

234 At every stage of the counseling and legal process, advocates and lawyers are encouraged to engage continually in safety planning. The advocacy community has stressed the importance of safety planning with survivors of domestic violence as "an integral part of domestic violence intervention practices by lawyers, judges, courts, and all community players, whether or not the victim remains with the batterer. Safety planning is critical because it offers the victim an action plan for staying alive." Buel, supra note 133, at 726.

235 See Maman et al., supra note 74, at 476.

236 For rural survivors, this problem is compounded by greater distances between services, fewer available services, and other barriers to accessing services, including concerns about privacy and confidentiality when all the community members know each other.

237 See generally Martha Wade Steketee, Lynn S. Levey & Susan L. Keilitz, Implementing an Integrated Domestic Violence Court: Systemic Change in the District of Columbia (2000) (addressing three interrelated components of a domestic violence unit--intake, a specialized clerk's office, and dedicated courtrooms); Epstein, supra note 220, at 3 (calling for prosecutors, judges, and the courts to work together in protecting victims of domestic violence).

238 Family Justice Ctr. Alliance, About Us, http:// www.familyjusticecenter.org/index.php/about-us/about-us.php (last visited Apr. 8, 2009). Other types of collaborations have occurred over time. See, e.g., Lois H. Kanter, Invisible Clients: Exploring Our Failure to Provide Civil Legal Services to Rape Victims, 38 Suffolk U. L. Rev. 253, 287-88 n.139 (2005) (describing a collaboration among lawyers, police, and social services to better serve sexual assault survivors); Louise G. Trubek, Embedded Practices: Lawyers, Clients, and Social Change, 31 Harv. C.R.-C.L. L.

Rev. 415, 421-24 (1996) (giving the example of lawyers providing services to clients at battered women's shelters in Wisconsin).

239 Epstein, supra note 220, at 29.

240 Id. at 29-31.

241 Family Justice Center Alliance, About Us, History, http:// www.familyjusticecenter.org/index.php/about-us/history.php (last visited Apr. 8, 2009).

242 The STOP (Services, Training, Officers, and Prosecution) Grant Program coordinates the criminal justice system response to domestic violence by uniting law enforcement, prosecutors, and victim services. U.S. Dep't of Justice, STOP Violence Against Women Formula Grant Program, http:// www.ovw.usdoj.gov/stop_grant_desc.htm (last visited Apr. 8, 2009).
In 2004, the President's Family Justice Center Initiative awarded grants totaling over $20 million to fifteen cities to create victim service sites that combine civil and criminal responses to violence. The Department of Justice's Office on Violence Against Women is leading the development of the victim service and support centers. The centers are modeled after Family Justice Centers in San Diego, Indianapolis, and Hennepin County, Minnesota, and may include victim advocates, civil attorneys, law enforcement, prosecutors, probation officers, forensic medical professionals, and chaplains, among other service providers. Press Release, U.S. Dep't of Justice, Attorney General Ashcroft Announces $20 Million for Communities Through President Bush's Family Justice Center Initiative (Jul. 21, 2004) (on file with the North Carolina Law Review). The development of such centers is to be commended, because service provision and support is especially important to ending domestic violence. Survivors' social support and the support of advocates and community resources have proven key to effective, lasting intervention in domestic violence, whereas women who encounter barriers when they seek services have poorer outcomes. Judy L. Postmus & Margaret Severson, U.S. Dep't of Justice, Violence and Victimization: Exploring Women's Histories of Survival 134 (2005), available at http://www.ncjrs.gov/pdffiles1/nij/grants/214440.pdf (reporting the results of a survey of 423 incarcerated and nonincarcerated women who had experienced abuse).

243 See Davila, supra note 64, at 55.

244 With the proliferation of the centers, Goodman and Epstein caution against treating survivors as having identical problems and needs or limiting service options to present providers. Goodman & Epstein, supra note 99, at 4 ("Battered women whose needs do not mesh neatly with available services may receive no assistance or may feel pressure to accept help that only poorly suits their needs or is even contrary to their interests."); Epstein et al., supra note 133, at 469 (explaining that empirical evidence shows that "victims frequently avoid and subvert community interventions that fail to acknowledge the realities and intricacies of their lives"); see also Davila, supra note 64, at 55 (finding that traditional anti-domestic violence programs have "focused on women's empowerment, assertiveness, and negotiation skills in a vacuum devoid of the sociocultural contextual factors of women's reality").

245 Maman et al., supra note 74, at 477.

246 Although domestic violence has now been identified as an AIDS risk factor, this new understanding has not been widely publicized or incorporated into women's AIDS prevention programs. See Davila, supra note 64, at 55 (discussing how public health experts are beginning to recognize that "[t]raditional AIDS prevention programs that are neither culturally sensitive nor gender specific place women, especially women involved in abusive relationships, at increased risk for abuse").

247 Ruth SoRelle, San Diego Family Justice Center Coordinates Services for Abuse Victims, 25 Emergency Med. News, Dec. 2003, at 33, 33 (describing the forensic medical unit's use of technology to document injuries, with an eventual goal of also providing medical care).

248 Selbin & Del Monte, supra note 12, at 119. Individuals often simultaneously face a multitude of intersecting legal problems, such as needing assistance with domestic violence, immigration, housing, public assistance, credit, employment, child welfare, child support, and other legal needs. This Article focuses on the intersections of domestic violence and HIV/AIDS because of the urgency of these independent and combined issues and the lack of discussion of this connection in legal literature to date (outside of problems surrounding partner notification laws).

249 There are several examples of combined health and legal service approaches. Kansas City, Missouri, and San Diego, California, are examples of cities with domestic violence programs located at children's hospitals to serve battered women with children. Other emergency rooms report efforts to implement protocols to screen for domestic violence and provide referrals for domestic violence resources. See Sandra J. Clark et al., Urban Institute, Coordinated Community Responses to Domestic Violence in Six Communities: Beyond the Justice System ch. 3 (1996), http://www.urban.org/url.cfm?ID=406727. In a hospital in New York, attorneys on a clinical care team and a hospital-based attorney assisted HIV-infected patients with guardianship, legal directives, housing, insurance, credit, and discrimination cases. Alice Herb, The Hospital-Based Attorney as Patient Advocate, 25 Hastings Ctr. Rep. 13, 16 (1995). A partnership between the Berkeley Community Law Center's HIV/AIDS Law Project and the Family Care Network is one example of an integrated model for serving low-income, HIV-positive women. The legal aspect of the project included a wide range of legal assistance, including wills, public benefits, guardianship issues, housing, and family law. See Selbin & Del Monte, supra note 12, at 125.
Before implementing an information-sharing system, it is essential to consider how integrated models implicate attorney-client and doctor-patient confidentiality. There are multiple possibilities in coordinating services that involve varying levels of information sharing and confidentiality waiver. Simply clustering services in one building would not require sharing information or risk waiving confidentiality. At the other end of the spectrum is a truly integrated service delivery model, as described by Selbin and Del Monte--these authors identify questions of whether the patient/client fully understands the risks in waiving confidentiality and is truly able to freely consent. Id. at 130. The Family Justice Center in San Diego describes how it is developing a system that allows agencies to "quickly and securely share information--so that victims will have to tell their story only once, rather than repeatedly conveying their traumatic experiences to various social, medical, legal and public safety professionals." Press Release, Fam. Justice Ctr. Alliance, Verizon Awards $1 Million to National Family Justice Center Alliance to Help Improve Services for Survivors of Domestic Violence (Apr. 4, 2008), available at http://www.familyjusticecenter.org/index.php/news-from-nfjca/news-and-events/news-room.php. Centers should research the implications of information sharing, including inadvertently affecting confidentiality and privilege, along with mandatory reporting requirements of some professions. Kanter specifically addresses this model:
In theory, "co-locating" civil lawyers with law enforcement and social service providers at community locations, without any merging of organizational structures, is ideal for providing clients with "one-stop shopping." The providers also benefit because they can easily communicate and coordinate their activities. In an effort to obtain these benefits, co-location of all domestic violence and sexual assault services is now being promoted by [the Office of Violence Against Women's] Family Justice Center (FJC) initiative. This effort, however, can only be successful if the privacy of client information remains under the clients' control, and clients are able to choose which services they want to access, and which they want to avoid. This requires that all parties are prepared to place strict limits on information sharing within the FJC and on their access to clients entering the center, limitations that some governmental agencies and institutions may find troubling. Thus, while co-location has a great many advantages for both victims and providers ... it is not a simple concept to implement.
Kanter, supra note 238, at 287 n.139.

250 Medical professionals should similarly screen for domestic violence and HIV risk, become aware of the relationship between domestic violence and HIV/AIDS, receive training to recognize the signs of intimate partner violence, engage in safety planning with patients in crisis, and be prepared to connect patients with other community and legal resources. See El-Bassel et al., supra note 69, at 169.

251 See Barbara Gerbert et al., When Asked, Patients Tell: Disclosure of Sensitive Health-Risk Behaviors, 37 Med. Care 104, 108-09 (1999) (finding that, "[d]espite physician concerns that patients may be uncomfortable or offended by behavioral risk questions," patients are actually willing to disclose such information).

252 See Erin M. Marcus, Screening for Abuse May Be Key to Ending It, N.Y. Times, May 20, 2008, at F5 (discussing how medical professionals generally fail to ask their patients about incidents of domestic violence).

253 Clinical guidelines recommend routine screening for domestic violence, assessments of safety and health, careful

documentation of abuse in medical records, and offering patients educational materials and referrals to community resources. See AMA Code of Medical Ethics Op. 2.02 (2007), available at http://www.ama-assn.org/ama1/pub/upload/mm/Code_of_Med_Eth// opinion/opinion202.html; Press Release, Family Violence Prevention Fund, New CDC Data Underscores Need for Health Care Providers to Assess Patients for Violence, Expert Says (Feb. 7, 2008), available at http:// www.endabuse.org/content/press_room/detail/958 (advocating for health care providers to receive training so that they are better equipped to recognize and treat health problems associated with domestic violence). There are numerous reasons for including questions about domestic violence in the routine medical history, including to educate patients, give patients an additional person to come to when in need of assistance, develop a relationship and build trust with a patient, and cause the patient to feel comfortable disclosing information over time. Interventions by health care providers can increase a patient's and children's safety and prevent further injuries or health complications. Understanding the presence of violence in the home also allows doctors to better understand a patient's symptoms and how to approach his or her self-management of an illness. See Marcus, supra note 252 (stating that abusive partners are more likely to interfere with the medical care of their victim); see also Barbara Gerbert et al., A Qualitative Analysis of How Physicians with Expertise in Domestic Violence Approach the Identification of Victims, 131 Ann. Intern. Med. 578, 580-83 (1999) (describing effective screening methods, including the framing of questions, educating patients, building trust, compassionate asking, and attentive body language).

254 Nancy Kathleen Sugg & Thomas Inui, Primary Care Physicians' Response to Domestic Violence: Opening Pandora's Box, 267 J. Am. Med. Ass'n. 3157, 3157-60 (1992).

255 Marcus, supra note 252. One woman reports that she appeared in her doctor's office many times with visible bruises, but no one ever asked her about the cause of her injuries. At a medical appointment, she asked her doctor to examine her swollen black eye and reported that her husband had hit her. Her doctor's only response was to say, "You'd better get out of that situation." Id.

256 Domestic violence victims may not be free to travel throughout the city, going from courthouse to social service agency to counseling, but they may be able to attend medical appointments for children or themselves. For someone experiencing high levels of control and isolation, a doctor's office or medical clinic may be the only opportunity for help. A survivor whose husband was convicted of raping her reports on the lack of effective medical intervention and states, "Looking back, I didn't know the resources that were out there. The doctor's office is a good place to go because it's neutral and it's confidential. It's not like telling your husband you're going to the police department." Id.

257 In addition to interference with medication and appointments, an abusive partner may limit the information and education opportunities about health concerns.
[T]he social isolation and restriction of activities in violent relationships are likely to reduce abused women's access to information about STDs and transmission risks. Additionally, internal barriers (such as high distress levels and substance use) that result from the trauma may increase the difficulty of thinking through, and acting on, new knowledge. The provision of accurate information about STDs in general and the heightened STD risks in abusive relationships should be considered a critical component of interventions for women.
Beadnell et al., supra note 33, at 684.

258 Lichtenstein, supra note 59, at 122-23.

259 See Cohen et al., supra note 32, at 564 ("A full range of domestic violence service referrals and appropriate provider training and responsiveness are critical components of effective HIV care programs for women."); see also Davila, supra note 64, at 55 ("The experience of physical, psychological, and sexual abuse of women in abusive relationships highlights the need to merge abuse and AIDS prevention strategies and programs."); Maman et al., supra note 74, at 462 ("Clearly, recognizing and incorporating the areas of overlap into their respective prevention strategies could strengthen both HIV and domestic violence programs.").

260 Factors that shorten the time between HIV infection and AIDS include older age, poor nutrition, being infected with more than one type of HIV, and severe stress. Factors that prolong the development of AIDS include closely adhering to a doctor's recommendations and a healthy diet. See Ctrs. for Disease Control & Prevention, supra note 58.

261 See Levine, supra note 22 (explaining that "late testers" face serious health consequences, have considerably damaged immune systems by the time symptoms arise or HIV- or AIDS-related infections occur, and face increased death rates). Nationwide, thirty-nine percent of cases fell into this category during the last decade, and more than two-thirds of AIDS cases in the District of Columbia are in the "late testers" category. Id.

262 See Herb, supra note 249, at 16 ("Timely legal intervention is important both to address the acute crisis in the patient's day-to-day life and to allow the patient to be drawn into a broader range of decisions, among them health care choices, which are also critical.").