Finding Common Ground in Batterer Intervention

Presented by John Hamel, Ph.D., LCSW

ADVIP International Conference, July 14, 2018

References Available Upon Request

Source: Hamel, J. Batterer intervention groups: Moving forward with evidence-based practice. (under review, *Violence and Victims*.

Introduction

- Disagreements among BIPs, victim advoctes and researchers – IPV a **social problem,** or a **mental health problem?**
- Many reject Duluth as unscientific, contrary to professional codes of ethics (Corvo et al., 2009; Lee et al., 2009); but Duluth remains entrenched regardless.
- What motivated this presentation:
  - ✓ Limited effectiveness of traditional BIPs, depending on methodology (Babcock, 2004; Eckhardt et al., 2013).
  - ✓ Promise of alternative approaches (Eckhardt et al., 2013)
  - ✓ My experience with A.A. and peer-led BIPs

Primary BIP Treatment Models

- Duluth Model
  1. Primary cause of DV are beliefs held by men about their **privilege** in society (Pence & Paymar, 1993).
  2. Highly-structured group format used to educate men on the patriarchal actions they use to **control women**, such as intimidation, isolation, and other forms of abuse, and to foster an egalitarian mindset.
  3. Regards BIP curriculum not as a "treatment," but re-education, one component in community response to DV.

- Cognitive-Behavioral Therapy (CBT)
  1. DV rooted not in gendered beliefs per se, but in **distorted thinking** about self and partner, and the utility of violence.
  2. Considers all relevant risk factors, including poor emotion regulation and difficulties coping with stress and conflict.
  3. Main intervention components include strategies that target thoughts, emotions, and behaviors, and are conveyed through a mixture of psychoeducation, homework assignments, and cognitive reframing.
  4. Interpersonal deficits targeted through a **skills training** approach.

- Process/Psychotherapeutic Model
  1. Domestic violence is an acting-out problem, rooted in one's upbringing, and is best understood in light of a client's emotional problems and social maladjustment.
  2. Long-term desistance is more likely when a client addresses these emotional and social issues, is empowered o get his or her needs met, and has achieved a positive sense of self.
  3. The primary vehicle for change comes from gaining **insight**, overcoming inner resistance, working through inner conflicts, **healing past trauma**, and feeling understood in a supportive therapeutic environment.

Definitions of Evidence-Based Practice

- From the social work perspective, Shlonsky and Gibbs (2004) define evidence-based practice as

  > "a systematic process that blends current best evidence, client preferences (wherever possible), and clinical expertise, resulting in services that are both individualized and empirically sound" (p. 137).

“By determining that the need or desire for power was the motivating force behind battering, we created a conceptual framework that, in fact, did not fit the lived experience of many of the men and women we were working with. The DAIP staff [...] remained undaunted by the difference in our theory and the actual experiences of those we were working with [...] It was the cases themselves that created the chink in each of our theoretical suits of armor. Speaking for myself, I found that many of the men I interviewed did not seem to articulate a desire for power over their partner. Although I relentlessly took every opportunity to point out to men in the groups that they were so motivated and merely in denial, the fact that few men ever articulated such a desire went unnoticed by me and many of my coworkers. Eventually, we realized that we were finding what we had already predetermined to find.“ (Pence, 1999).

BIP Standards Recommendations

(Cannon et al., 2016; Based on exhaustive literature review by 17 researches at major research institutions):

- Holding offenders accountable requires a **multi-system response**.
- Treatment should be based on the **needs** of that individual and **threat** he or she presents to current and future victims.
- Treatment should be delivered by providers with substantial and **accurate knowledge** of partner abuse.
- Treatment plans should be determined through a **thorough psychosocial assessment** .
- Research does **not support current mandates** regarding modality or treatment models.

- Treatment should be based on **current best practices** informed by empirical research on treatment outcome, treatment engagement, and risk factors for PA recidivism.
- Research does **not support different curriculum** for male and female offenders.
- **Length of treatment** not necessarily related to outcomes
- No evidence to mandate **same-gender group** composition
- **High-risk offenders**, and certain populations (e.g., trauma victims) require special interventions, but many low-risk offenders can benefit from a generic type of evidence-based treatment.

Risk Factors for IPV Perpetration

- Primary Factors
  1. Stress from low-income or unemployment
  2. Aggressive personality, including pro-violent beliefs.
  3. Poor impulse control, anger management problems.
  4. Alcohol and drug abuse.
  5. Being in a high-conflict/abusive relationship.
  6. Experienced violence/dysfunction in family of origin.
- Traditional **sex role beliefs** not a risk factor overall.
- Risk factors are about the **same across gender**.
- Recidivism risk factors: history of violence, substance abuse

Risk-Need-Responsivity Model

- Risk = **Amount of treatment**; Need = **Risk factors to target**; Responsivity = **Use of relationship, engaging the client**
- Colorado Model (Gover, 2011), Florida study (Coulter & VandeWeerd, 2009)
- "The responsivity principle stresses the importance of features of curriculum design and program delivery that promote understanding and relevancy for participants for whom it was designed…by the successful **matching of treatment strategies to their learning styles, motivation level, and cultural context**."

- Stewart et al. (2013), pp. 512-513

Overlap Across Treatment Models

- El Hombre Noble Buscando Balance (Carillo & Zarza) group for Latino male batterers addresses:
  1. Environmental, intergenerational violence
  2. Gender power imbalance
  3. Emotional distress/mental health issues; attachment
  4. Poverty and unemployment
  5. Issues related to acculturation
  6. Role of substance abuse

- Duluth (Pence & Paymar, 1993; Miller, 2010)
  - ✓ Use of control log, role plays, videos, action plans, peer support to foster responsibility, respect, honesty, trust, partnership and negotiation.
  - ✓ Basic skills: Time out, sitting down when agitated, positive self-talk
  - ✓ Even as it downplays psychological issues, Duluth acknowledges that some individuals need additional help.
  - ✓ Helps clients overcome minimization and denial, and empower them to cease their abuse.
- Duluth, CBT not same; but large overlap, and many providers not allied to one model (Cannon et al., 2016).

Peer Versus Therapist Group Facilitation

LIMITATIONS OF PEER COUNSELING/FACILITATION

- Lack of appreciation for scientific method and research knowledge base major limitations.
- Lack understanding of human development, personality, principles of behavior, and learning disabilities restrict ability to properly diagnose or effectively handle mental health issues.
- Lack of professional accountability, compared to licensed therapists, can lead to counter-transference, other problems.

ADVANTAGES OF PEER COUNSELING/FACILITATION

1. AA example: Similarities between A.A. and CBT (McGrady, 1994); works overall as well as relapse prevention, harm reduction models (Knack, 2009).
2. Having a college degree or a professional license does not automatically confer good judgement that comes from life experiences.
3. Peer facilitators provide credible example for change; testimony of peer facilitator program graduates I have talked to; Manalive observations.
4. Edleson and Syers (1990): RAC outcome study of 70 men in BIP found self-help discussion group led by reformed offender as effective as a structured educational group led by a professional.

Engaging Clients

- Experienced social workers on handling involuntary clients (Jacobson, 2013):
  - ✓ Expect resistance when working with any involuntary clients, which may reflect a mistrust of authority rather than simply denial or unwillingness to change.
  - ✓ A strong facilitator-client alliance important in helping clients “buy in” to the change process.
  - ✓ “It is important to be able to see the client as a person and that they are capable of change.”

- Motivational Interviewing (Dia et al., 2009):
  1. Motivation to change is **elicited from the client**, not imposed from without, and direct persuasion is not effective in resolving ambivalence.
  2. The counseling style is generally a quiet and eliciting one.
  3. The counselor helps the client to examine and resolve ambivalence, but only the client can accomplish this.
  4. Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction.
  5. The therapeutic relationship is a **partnership**.

ENGAGEMENT IN BIPS: MI RESEARCH

- Groups that incorporate MI:

    1. Have better client-facilitator alliance and less dropouts

    2. Significantly associated with responsibility-taking, homework compliance, group cohesion and adherence to group norms.

- MI predicts lower psychological and physical abuse, based on victim reports.
- High group cohesion predicts lower levels of abuse.

Psychotherapy Outcome Studies

Importance of common factors (Wampold & Imel, 2015):

Common factors:	d (effect size)	r (effect over control)
✓ Alliance	0.57	27%
✓ Empathy	0.63	30%
✓ Goal Consensus/Collaboration	0.72	34%
✓ Positive Regard/Affirmation	0.56	27%
✓ Congruence/Genuineness	0.49	24%
✓ Expectation	0.24	12%
✓ Cultural adaptation	0.32	16%
Differences between treatments	**0.20**	**10%**

- However:

  "The effectiveness of psychotherapy is not derived simply from having a relationship with the patient (i.e., just two people in a room talking), even if that relationship is empathetic, caring, and nurturing, as important as those factors are. According to the Contextual Model, **the therapist must provide an explanation of the client's problem and there must be therapeutic actions consistent with the explanation (i.e., a treatment) that involve means for overcoming or coping with the client's problems**. The client needs to accept and engage in the therapeutic process – not simply be engaged with the therapist but actively working toward a goal in a coherent way" (pp. 258-259).

Research on Group Counseling

- Guidelines for more effective groups (Fuhriman & Burlingame, 1990; Morran et al. (2004):
  - ✓ Strive for positive involvement through genuine, empathetic and caring interactions.
  - ✓ Engage in appropriate and facilitative self-disclosure.
  - ✓ Help members make maximum use of group role models.
  - ✓ Provide appropriate level of structure.
  - ✓ Confrontations should be respectful.
  - ✓ Enforce group norms.
  - ✓ Promote a feeling of safety.

- The Group Engagement Measure (GEM; Macgowan, 2006)
  1. Validated and reliable instrument for gauging the level of client engagement in group, based on research evidence.
  2. Factors **correlated with client engagement**:
     - ✓Attendance
     - ✓Contributing
     - ✓Relating to facilitator
     - ✓Contracting (supports group norms)
     - ✓Working on own problems
     - ✓Working on other group members' problem

CONTACT: Mark Macgowan, School of Social Work, Florida International University 305-348-5883; Macgowan@fiu.edu

Insights from Facilitators and Clients (Summary)

- Engagement a process; members need to "buy in" to what group is offering, facilitator should "roll with the resistance"
- Greater motivation from insights on effects of IPV on loved ones, and desire to change than avoidance of incarceration
- Importance of mutual respect between facilitator and group members
- Members value identification, support, leading by example
- Members benefit from learning emotion management, interpersonal skills
- Group experience/skills lead to responsibility-taking, less dependency on partner
- Members want adjunctive services (e.g. for substance abuse)

Review and Recommendations

Best Practices in "Big Three" Areas of Group Treatment

Curriculum Content	Facilitator-Client Relationship	Group Leadership
What works: Address known risk factors through education, homework, role plays, etc. Research base: Risk factor literature, BIP outcome literature, RNR findings with all offender populations.	What works: Use of client-centered and MI techniques. Research base: Psychotherapy and BIP outcome findings	What works: Create group culture in which clients are engaged, cooperative and learning. Research base: Research on mandated populations, BIP outcome studies and qualitative studies.

- When **peer counseling** is appropriate
  1. Facilitator has thorough training in domestic violence characteristics, causes and consequences, group process, and evidence-based intervention.
  2. Supervision by licensed mental health professional.
  3. Work within a psychoeducational model.
- When **mental health professional** required
  1. Couples and family therapy.
  2. With clients exhibiting mental health issues.

- Understand who your clients are, and acknowledge when your program may not be suitable for a particular client – e.g., trying to convince an egalitarian man that he is a misogynist or "patriarchal" may lead to unnecessary resistance and reduced engagement.
- Some clients may benefit *despite* some features of your model, rather than because of them.
- Keep an open mind; learn from other models and approaches.
- Be willing to look at yourself and grow personally (e.g., transference dangers; Boston et al, 2010 facilitators' awareness of their control issues.)
- Keep up, as best as you can, with new research in the field.
- Network with other providers and researchers with membership in ADVIP (www.battererintervention.org)

Thank You!

John Hamel, Ph.D., LCSW

www.JohnHamel.net * Johnmhamel@comcast.net

(415) 472-3275 * San Francisco Bay Area, CA

Batterer Intervention Groups:
Moving Forward with Evidence-Based Practice 6-Hour Video
Now available at www.domesticviolencetrainings.org

(8 CEUs Available)