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Interventions for Perpetrators of Intimate Partner Violence: An I^3 Model Perspective

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The Instigating-Impelling-Inhibiting model of intimate partner violence (IPV) etiology, or "I^3 Model," is presented as a meta-theoretical alternative to traditional perspectives regarding treatment models for perpetrators of IPV. The I^3 Model is a meta-theoretical approach to understanding IPV risk that, when applied to IPV intervention programs, incorporates practically any therapeutic component that aims to decrease individual's exposure to instigating contexts, target any individual or situational factor that impels IPV, and increase an individual's ability to inhibit an aggressive response. In this review, we first briefly summarize the IPV literature and existing intervention models. Second, we review the I^3 Model and illustrate its promise as a guiding framework for understanding IPV risk and its broad relevance to etiology and intervention. Third, we discuss the conceptual application of this framework to intervention with IPV perpetrators. Fourth, we identify factors that may promote as well as complicate I^3 Model-related intervention developments.

KEYWORDS: etiology and risk factors; individual; couples and family interventions; BIPs: characteristics, process, and outcome studies

Intimate partner violence (IPV) is a serious public health problem that is associated with myriad-negative consequences. Intervention programs for perpetrators of IPV are often used as an alternative to incarceration for individuals convicted of IPV-related offenses. Developing successful intervention programs is critical for reducing aggression within couples and for improving the quality of life of both partners. While iterations of these intervention programs have existed for decades, the history of these programs is riddled with political and theoretical controversy. A full review of the history of IPV intervention programs is beyond the scope of this article, and many reviews of this literature already exist (e.g., Murphy et al., 2019). Despite efforts over the last several decades to successfully rehabilitate individuals who use violence and

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aggression in their relationships, most of these intervention programs, regardless of their theoretical orientation, have yielded only modest indications of effectiveness (for a review, see Murphy & Richards, 2020). The lack of consistent positive outcomes is likely due to the interactive complexity of distal and proximal factors involved in IPV perpetration and the largely unidimensional nature of existing treatments.

The purpose of this article is to highlight the limitations of these unidimensional, one-size-fits-all approaches and to advocate for a flexible, multidimensional, individualized approach to treatment guided by the I^3 Model framework (Finkel, 2007). As will be discussed, the I^3 Model approach allows for the integration of a wide variety of treatment techniques, regardless of their theoretical focus, with an emphasis on understanding the unique risk factors for each individual and designing a tailored treatment program to address those risk factors. We will also discuss anticipated challenges of this approach and existing limitations to its implementation, with recommendations for future research and clinical practice.

LIMITATIONS OF EXISTING IPV INTERVENTIONS

While a variety of IPV interventions have been developed, they tend to consist of relatively short-term manualized treatment programs that are designed to apply broadly to clients who have used IPV without much consideration of co-occurring conditions and individual complexity that is so often seen in clinical settings (Murphy & Eckhardt, 2005). While this blanket approach to treatment lends itself to rigorous empirical examination through randomized controlled trials, it generally lacks flexibility and does not allow clinicians to address treatment targets that may be relevant for an individual client but that are not included in the treatment manual. For example, interventions based on cognitive behavioral therapy (CBT) are typically centered around identifying and challenging distorted cognitions, changing maladaptive behavioral patterns, improving communication skills, and providing tools for enhancing emotion regulation (ER). While these treatment targets are likely relevant for many individuals who use IPV, there are many additional risk factors that may be playing a key role in maintaining IPV behaviors that would not be addressed through traditional CBT interventions (e.g., experiential avoidance, substance misuse, posttraumatic stress disorder [PTSD] symptoms).

Some manualized intervention programs have moved toward a more tailored approach by integrating traditional CBT-based IPV interventions with additional treatment components designed to target common co-occurring conditions such as substance misuse and trauma exposure (Easton et al., 2018; Taft et al., 2016). However, it is often the case that clients present to treatment with a complex constellation of IPV risk factors and co-occurring conditions and clinicians may be faced with the challenge of either choosing a treatment program that addresses only a subset of the client's concerns or forging their own path without any solid guidance on how to structure the client's treatment plan. What is needed is a more individualized approach to assessment and treatment planning that allows the clinician to identify each individual client's risk factors and to develop a specific course of treatment that will address those factors. Rather than relying on one manualized treatment, clinicians may need

to pull techniques and skills from multiple treatment approaches and determine an appropriate order in which to prioritize these various components to best achieve the goal of violence reduction. While this may be a more challenging approach to treatment, clinicians may find that this framework yields lower rates of IPV recidivism and higher rates of treatment retention and engagement. In order to facilitate this type of intervention strategy, we can turn to a meta-theoretical framework, ***the I^3 Model*** (Finkel, 2007), for guidance.

THE I^3 MODEL

IPV is a complex behavior with a multitude of interactive distal and proximal risk factors. In order to successfully mitigate IPV risk and to prevent future recurrence, a comprehensive approach to intervention and prevention that takes into account its multifaceted nature is necessary. Taking such a multidimensional and multitheoretical approach can be challenging, and thus it is helpful to have a framework for organizing these risk factors. The I^3 model (Finkel, 2007, 2014) serves as a meta-theoretical framework that can facilitate the organization of these factors into a comprehensive approach to assessment, case conceptualization, and intervention. This framework is considered "meta-theoretical" in that it is theoretically inclusive, thus allowing researchers to incorporate the most empirically supported theories available, including sociocultural, psychological, and criminological theories, as a means of establishing optimal models of predicting IPV risk (Finkel & Eckhardt, 2013).

The I^3 model has been applied to many problematic behaviors, including IPV perpetration (Finkel, 2007; Finkel & Eckhardt, 2013), and begins with the basic assumption that people are more likely to perpetrate IPV when the strength of the urge to act aggressively exceeds the strength of the inhibitory forces counteracting this urge. According to the model, three key processes underlie IPV perpetration: *i*nstigation, *i*mpellance, and *i*nhibition (with the italicized vowels representing the three *I*s in the I^3 Model).

Instigating factors consist of provoking circumstances or situations that normatively trigger an individual to behave aggressively. Instigators may stem from the target of the aggression (i.e., partner) or from sources external to the couple (Slotter & Finkel, 2011), and provide the initial momentum toward an aggressive action. Examples of instigating factors include relationship conflict (e.g., Leone et al., 2016) and IPV victimization (Stith et al., 2004). Of course, people are exposed to instigating influences every day, but few actually lead to IPV. Thus, other processes are necessary to determine whether someone will perpetrate IPV at a specific point in time following provocation.

Impelling factors psychologically prepare an individual to experience a strong urge to aggress when encountering instigation in a particular context. Impellors can include dispositional personality traits that accelerate aggression (antagonism), attitudes approving of violence, beliefs, or assumptions that partners should act a certain way, and interpersonal habits that the individual brings to each interaction with the partner that increase the likelihood of IPV perpetration (e.g., belligerent defensiveness). For example, trait anger (Birkley & Eckhardt, 2015), anger

rumination (Watkins et al., 2015), and antisocial traits (Taft et al., 2012) are all empirically associated with an increased risk of IPV perpetration. Impellors can also include any cognitive, affective, or physiological experiences that are activated during a given conflict with a partner and which contribute to aggressive responses (e.g., interpreting a partner's behavior as hostile in nature). In addition, more distal life history factors such as experiencing childhood physical abuse (Maldonado et al., 2015) can increase one's risk of behaving aggressively in the presence of instigation. Thus, instigating and impelling factors interact to determine the basic likelihood that the person will perpetrate IPV.

Inhibiting factors counteract instigating and impelling factors to mitigate the urge to act in an aggressive manner (Slotter & Finkel, 2011). For example, adaptive ER strategies or a fear of negative consequences (e.g., arrest) could prevent someone from using physical aggression in response to a stressful or threatening situation with their intimate partner. The integrity of these inhibitory capabilities may be compromised by various *disinhibitory factors*, such as alcohol intoxication, that decrease the effectiveness of inhibitory efforts and, therefore, increase the likelihood that an aggressive urge will lead to IPV.

The authors of this article are frequently asked about whether one or another correlate of IPV perpetration is an instigator, impeller, or inhibitor. Importantly, extant literature does not exclusively establish IPV perpetrator variables as instigators, impellors, or inhibitors/disinhibitors in any sort of *a priori* manner. Rather, theory and/or empirical evidence are used to guide I^3 categorizations (Finkel & Hall, 2018). Once organized, these factors present the opportunity to examine their main effects and, more importantly, their interactions with other relevant risk factors present for individuals of interest at specific points in time. For example, adverse childhood experiences are associated with IPV during adulthood; do such experiences act to impel partner-directed aggression? Or do these experiences serve to weaken individual's abilities to withstand certain situations or specific strong emotions (i.e., a disinhibitor)? The answer is not predetermined and depends on the specific theory under consideration that incorporates these childhood factors, which is likely to be interactional in nature; it is within this theory-driven flexibility that the I^3 Model offers clinicians an innovative framework to predict, with greater accuracy, whether a given interchange between intimate partners will lead to violent versus nonviolent outcomes if they can discern the strength and interactive patterning of instigation, impellance, and inhibition factors for any given client.

The main theory drawn from the I^3 Model is known as "Perfect Storm Theory" (Finkel, 2007), which posits that ***the greatest likelihood for IPV occurs when instigation and impellance processes are strong and inhibitory processes are weak.*** Several prior investigations have found empirical support for the predicted two- and three-way Perfect Storm interactions across diverse samples, measurement and assessment techniques, and aggression paradigms (Finkel, 2014; Finkel et al., 2012; Watkins et al., 2015). For example, Birkley and Eckhardt (2019) examined the association between ER strategies and IPV perpetration in a college student sample and found a three-way "perfect storm" interaction between high instigation, high-trait anger (high impellance), and usage of ineffective ER strategies (low inhibition)

in predicting IPV-related behaviors during an imagined relationship scenario. Blake et al. (2018) reported a significant three-way "perfect storm" interaction among trait negative urgency (impellance), relationship quality (inhibitor), and cognitive reappraisal training (inhibitor) on college students' aggressive vocalizations to a relationship partner during an imagined relationship conflict. More specifically, when relationship quality was high, the impelling effect of negative urgency on aggressive vocalizations was attenuated by cognitive reappraisal training; when relationship quality was low, the attenuation effect of cognitive reappraisal training was no longer apparent.

CLINICAL IMPLICATIONS OF THE I^3 MODEL

While the treatment implications of the I^3 Model have not been widely disseminated, there are reasons for optimism about the clinical relevance of incorporating this approach into assessment, case conceptualization, and intervention planning. Importantly, the field already possesses the assessment tools and intervention techniques that can be used with such an approach. Consider this: every counselor or interventionist working with IPV perpetrators, whether voluntary or court-mandated, in a group or individual setting, approaches their work from the perspective of a specific theory or set of theories about the nature of IPV risk prior to the start of treatment. In addition, they have a set of associated treatment targets in mind that are embedded in their preferred intervention approach. This is the case regardless of the specific theory or theories that they are applying, whether they are feminist-centered, trauma-informed, CBT-driven, and so on—any empirically based model that allows one to consider the components of the I^3 Model is relevant.

From the standpoint of the I^3 Model, there are no *a priori* preferences afforded to any specific intervention model that can be applied with IPV perpetrators, as long as the approach conscientiously addresses theory-relevant and empirically justified instigating, impelling, and inhibiting factors, as well as their interaction, in understanding IPV-related outcomes. Conversely, if treatment approaches do *not* allow for a consideration of the importance of provoking incidents (instigators), individual or contextual factors that establish a "blueprint" for an aggressive response (impellors), factors that seem to disrupt self-control (disinhibitors), or skills that promote the building of resistances to aggressive inclinations (inhibitors), then not only do those interventions not align with the I^3 Model approach, but (more importantly) they also signal that they are not approaching IPV risk/reduction from an empirically tenable perspective. Such interventions are likely to be ineffective, both in terms of the violence-reducing properties with any particular client as well as in studies examining their broader group-level effectiveness. Given its meta-theoretical nature, the I^3 framework transcends unidimensional approaches to IPV assessment and intervention and can integrate components of various treatment approaches and individual treatment techniques in order to meet the unique needs of each individual client.

Elsewhere (Eckhardt et al., 2014), we have outlined how the I^3 Model could be applied to IPV offenders in a forensic setting, noting that the field is gradually

shifting toward etiologic and intervention models that offer broader viewpoints concerning risk factors for IPV extending beyond that of any specific unidimensional theory, and outlining how such models may translate into more focused interventions for perpetrators. Specifically, we outlined one potential empirically based approach to IPV intervention that integrates motivational enhancement and CBT elements for IPV offenders (Murphy & Eckhardt, 2005) to organize behavior change efforts around the three central I^3-related processes: Instigation, Impellance, and Inhibition. CBT-based techniques to modify instigators include various forms of stimulus control, whereas more traditional cognitive restructuring and emotion control elements form the basis of techniques designed to modify factors that impel IPV. Problem-solving and self-control replenishing techniques can assist in building the client's self-regulatory skills, and elimination of the disinhibiting effects of substance misuse can further generate more efforts to regulate behaviors in close relationships. Further investigation is needed to evaluate the active components of this approach, and to examine factors that predict its effective implementation (cf. Eckhardt et al., 2014).

CHALLENGES OF APPLYING THE I^3 APPROACH TO GROUP TREATMENT

While there are clear benefits of an I^3 approach to IPV intervention, it is important to consider the feasibility of such an approach given current treatment policies and constraints. IPV perpetration and victimization are most often detected and intervened upon in settings with limited resources (e.g., medical and criminal justice settings), which precludes in-depth and multidimensional assessment. Further, although person-centered intervention—informed by individualized assessment and case conceptualization—may be essential in an I^3 approach to treatment (Eckhardt et al., 2014), the dominant mode of intervention remains group therapy (Maiuro & Eberle, 2008).

There are a number of practical ways to modify current group intervention/treatment for IPV such that it aligns more closely with an I^3 framework. From an I^3 perspective, it is important to create more flexible, person-centered interventions that can be delivered within a group modality. As outlined above, such interventions should begin with a thorough assessment of I^3 risk factors, co-occurring priorities (e.g., justice involvement or substance use), and motivation for change that align with the three core dimensions of instigation, impellance, and inhibition. Then, facilitators/therapists can make necessary adaptations to the group intervention to increase the likelihood of consistent treatment participation and meaningful behavioral change. While a thorough I^3-related assessment is seemingly cumbersome, additional time spent to clarify instigators, impellors, and inhibitors/disinhibitors at the outset of treatment may be counterbalanced by a more efficient intervention.

Group treatment can also be improved by establishing and enforcing standards for the number of individuals treated within a group therapy approach (Easton & Crane, 2016). For example, the U.S. Department of Veterans Affairs, Veterans Health Administration (2013) suggests a limit of three to five individuals per group with groups of 10 or more individuals being contraindicated (SAMHSA,1999). From an

I^3 perspective, limiting the number of individuals in treatment groups will ensure individualized attention within a group framework and also ease resource burdens by reducing clinician workload. Moreover, research suggests that treating low- and high-risk perpetrators in the same group is contraindicated because high-risk perpetrators' behaviors in a group context may impede meaningful change among low-risk perpetrators (Babcock et al., 2007). I^3-informed assessment may facilitate intentional group configurations, such that high- and low-risk perpetrators (i.e., those with the "perfect storm" high instigation, high impellance, and low inhibition configuration relative to those with low instigation, low impellance, and high inhibition) are not treated in the same therapy group (Easton & Crane, 2016).

Eckhardt et al. (2014) outlined an I^3 Model approach to treatment that incorporates motivational interviewing (MI) techniques (Miller & Rollnick, 2002), which can be applied within the context of group treatment for IPV. MI is an effective tool that can be used to elicit and reinforce clients' personal motivation for change, and reviews of the literature suggest that MI increases retention of IPV perpetrators in treatment (e.g., Soleymani et al., 2018). In order to enhance the effectiveness of group treatment and to create a more individualized treatment context, an initial MI session could be conducted prior to the initiation of the group intervention. During this session, the clinician could provide the client with personalized feedback from the initial assessment, with an emphasis on exploring the client's unique instigating, impelling, and (dis)inhibiting risk factors. Individual booster sessions could be conducted as needed in order to facilitate the application of skills learned in group to each client's personal circumstances. While an I^3 approach to treatment has not yet been empirically tested, specific recommendations, adaptations, treatment materials, and assessment measures for an I^3-consistent, 12-week CBT intervention can be accessed by referencing Eckhardt et al. (2014).

CONCLUSION

Substantial progress has been made in the development of interventions for individuals who abuse their relationship partners. Over time, there has been a notable shift away from narrowly-focused, unidimensional ideologies, toward etiology and intervention models that offer broader viewpoints concerning risk factors for IPV and how this understanding of risk relationships may translate into more focused interventions for perpetrators. However, despite a plethora of different intervention models based on many different theoretical conceptualizations, concerns about the lack of effectiveness of these interventions persist (Karakurt et al., 2019; Murphy et al., 2019). This suggests that it may be time to reconsider our broader understanding of the origins of IPV and how we are able to translate the complexity of factors involved in IPV perpetration to interventions for IPV perpetrators. In this review, we suggest that a promising process dynamic risk model of IPV etiology—the I^3 Model (Finkel, 2014; Finkel & Eckhardt, 2013)—may be particularly useful as a guide to promote more conscientious and empirically supported translation efforts. While we outline one such I^3 Model-informed approach based on motivational enhancement and CBT

techniques (Eckhardt et al., 2014; Murphy & Eckhardt, 2005), the specific components that can be incorporated into an I^3-based approach are flexible and can support a multitude of different intervention approaches. The key is to organize behavior change efforts around the three central processes of the I^3 Model: Instigation, Impellance, and Inhibition. Such an approach boils down to the following series of questions:

- Can the intervention successfully modify instigators and reduce the likelihood of the individual being exposed to partner-involved provoking events?
- Does the intervention systematically and effectively assess and intervene on the wide range of factors that might set-the-stage for, or otherwise impel, IPV?
- Does the intervention replenish the individual's ability to resist acting abusively even when the situation and their inner monologue are demanding that they lash out and punish?
- Does the intervention aim to reduce or eliminate other disinhibiting factors, such as working through difficulties associated with childhood trauma, reducing the proximal effects of substance misuse, or modifying other interpersonal habits that work against the person's self-control?

The answers to these questions provide the initial steps to considering whether any given intervention is aligned with the I^3 approach. Efforts are now needed to evaluate the effectiveness of this meta-theoretical approach as it relates to the development and evaluation of IPV interventions.

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