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The Double Standard of Accountability: A Call for Treatment Integrity of IPV Offender Programs

Ashley N. LeBlanc
Michael D. Mong, PhD
The University of Southern Mississippi, Long Beach

In this study, we explain the importance of treatment integrity by listing and exploring state standards for service providers of intimate partner violence (IPV) perpetrator programs across the United States. The overall expectations of batterer intervention programs (BIPs) will be discussed as we compare and contrast the Duluth Model with evidence-based practice. Expectations of treatment efficacy will be explored from the stance of the professional code of ethics and ethical practice. The context for this article is inspired by the following issues: (a) mental health professionals' ethical obligations to clients and to standards of practice; (b) the value of treatment integrity; (c) expectations regarding program efficacy; (d) the nature of court-mandated batterer intervention programs. Potential ethical concerns that are explored include: failure to consider and utilize research evidence, failure to ensure treatment integrity, inadequate assessment/diagnosis, failure to connect assessment to treatment, using a diagnosis on a client not identified in the *DSM–V*, giving a diagnosis without proper credentials or evaluation of the client, and imploring a homogeneous approach to a complex behavior.

Keywords: BIP's; treatment integrity; ethics; treatment efficacy

The purpose of this article is to explore treatment integrity and the ethical responsibilities of mental health professionals who currently facilitate Duluth-style interventions for perpetrators of intimate partner violence (IPV). The available literature for offenders of IPV is certainly not scarce, nor are theories of causal variables. Researchers have given a great deal of attention to various aspects of IPV perpetration, such as typologies, subtypes, treatments, diagnoses, causes, demographics, socioeconomic status, personality traits, and even legislation. However, research has yet to conclusively confirm an effective therapeutic model (Corvo, Dutton, & Chen 2009; Feder, Wilson, & Austin, 2005; Gondolf, 2011; Jackson et al., 2003; Murphy

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& Ting, 2010; Saunders, 2008; Smedslund, Dalsbø, Steiro, Winsvold, & Clench-Aas, 2011; Stover, Meadows, & Kaufman, 2009).

Ironically, exploring the cycle of violence has quite a cycle of its own. There seems to be an abundance of unanswered questions regarding the effectiveness of current treatment models. Positive, yet insignificant, effects seem to be the consensus of current research (Arias, Arce, & Vilarino 2013). According to Badcock et al. (2016, p. 416), "it is argued that the question becomes one of not whether the programs work but under what conditions do they work and for whom."

Historically in the United States, IPV offender intervention models have been dominated by batterer intervention programs (BIPs) (Babcock et al., 2016). The overarching theme of BIPs is to guide the offender to take accountability for their behavior. This accountability is solely focused on resolving men's sexist attitudes, which is believed to be the cause of their violent behavior (Barocasa, Emery, & Mills, 2016). The current focus of IPV literature certainly does not shy away from solely blaming the offenders, especially within the Duluth Model (Dutton, 2007). However, what is currently not in focus is IPV literature supporting treatment integrity. One may ask how mental health practitioners, with good conscious, are able to deliver a method of treatment that has had little to no significant effect on its clients for the last 30 years (Dutton & Corvo, 2006). Is it possible that counselors demanding offender accountability have actually lost sight of holding themselves accountable for the integrity of their therapeutic approach?

THE DULUTH MODEL: OVERVIEW AND BRIEF HISTORY

The Duluth Model, known as a BIP, was established in 1981 and developed by a small group of activists of the battered women's movement (Pence & Paymar, 1993). The Duluth Model curriculum, rooted in feminist and sociocultural concepts, holds as its core belief that males perpetrate abuse as a means of power and control derived from historical male privilege (Bohall, Bautista, & Musson, 2016) (see Table 3 in appendix). The purpose of creating this model was to provide an alternative choice for jail time to offenders convicted of domestic assault (Corvo et al., 2009). Program strategies include: "tension reduction exercises, communication and problem-solving skills training, appropriate use of 'time-out,' and building empathy towards the victim" (Herman, Rotunda, Williamson, & Vodanovich, 2014, p. 3). Specifically, the curriculum has eight themes: "negotiating and fairness, non-threatening behavior, respect, trust and support, honesty and accountability, responsible parenting, shared responsibility, and economic partnership" (Pence & Paymar, 1993, p. 31). Although all of these are noble skills, IPV research clearly states that psychoeducation alone has little to no effect. Whereas, a therapeutic alliance, contingent on an authentic relationship between client and therapist, is the most necessary and sufficient component for change (Dutton & Corvo, 2006; Soleymani, Britt, & Wallace-Bell, 2018). Given that the Duluth Model is formatted as a group intervention, it may be difficult to establish a therapeutic alliance on an individual basis.

Just as a strong therapeutic alliance between the counselor and client is critical for effective counseling, the ability of the facilitator to form group cohesion is also critical when conducting group therapy (Yalom & Leszcz, 2005). Effective facilitators know the importance of establishing group norms, creating a safe environment, and prescreening to form groups of individuals facing similar problems. It is not only critical that the facilitator know how to manage a group, but the facilitator must also possess certain characteristics that have been shown to aid in successful group outcomes where the clients are more engaged and motivated to change. Among these characteristics are: being nonjudgmental, honest, humble, authentic, nonconfrontational, respectful, committed, empathic, willing to challenge client behaviors, having unconditional positive regard, and possessing adequate knowledge about IPV with the ability to provide useful services and tools to produce change (Hamel, 2019).

Therapists who actively and continuously conduct assessments are better able to reduce attrition rates by determining when a client has ceased progressing in treatment, discern why this has occurred, and intervene accordingly (Reese, Norsworthy, & Rowlands, 2009). Reduced recidivism is contingent on a client's willingness to continue in the program. According to Babcock et al. (2016), a therapist's ability to empathize and build a sense of trust with the client, instilling within them hope and a value of self, has a positive effect on a client's willingness to continue treatment by supporting and facilitating, with the client, specific goals focused on strengths and solutions.

Rather than utilizing qualified clinicians, the Duluth Model was specifically designed to allow programs to be led by paraprofessionals (Dutton & Corvo, 2006). To become an IPV facilitator, potential employees are taught the belief system behind the model, the core values that support the model, and how to address offender resistance during treatment. It can be argued that rehabilitation efforts should be administered by qualified health professionals, given the complexity of IPV etiology and the link between intervention effectiveness and diagnosis as assessments and diagnoses fall outside the scope of practice of paraprofessionals (Bohall et al., 2016).

PSYCHOLOGICAL RISK FACTORS OF DOMESTIC VIOLENCE OFFENDERS

Perpetration of IPV is best understood when considering the overlapping risk factors and influence of early trauma, attachment disruption, parental rejection, high anger, and borderline personality traits (Corvo et al., 2009). Empirical evidence reveals perpetration of IPV to be a disorder of intimacy dysfunction, poor impulse control, substance abuse, and/or neuropsychological vulnerability. Despite the clinical and etiological link between IPV perpetration and the stated disorders, the Duluth Model views them as practically irrelevant (Corvo, Halpern, & Ferraro, 2006). The program manual for the Duluth Model, claims: "most group members are participating not because of a personal or family dysfunction but rather because violence is a socialized

option for men." They go on to also state, "to attach a clinical diagnosis to the 'batterers' use of violence provides a rationalization for behavior that may not be accurate" (Pence & Paymar, 1993, p. 23).

EXPECTATIONS ABOUT PROGRAM EFFICACY

It is difficult to understand why any type of program proven ineffective would be state-mandated and portrayed as the only acceptable approach to be forced on offenders (Corvo et al., 2009). Nonetheless, availability of IPV perpetrator rehabilitation program alternatives are limited in most jurisdictions (Feder et al., 2005). Duluth-type programs claim they are neither treatment nor therapy (Corvo & Johnson, 2003), and even the mandating agencies acknowledge the ineffectiveness of these programs (New York Office for Prevention of Domestic Violence, n.d.), while offering assurances of rehabilitation to victims of partner abuse, perpetrators, and judicial system (Corvo et al., 2009).

The main goal of the Duluth Model is on community responses for the purpose of holding offenders accountable (Pence & Paymar, 1993). In fact, it demands accountability regardless of the program's effectiveness. Participants enrolled must express full ownership of their behavior choices against their partner(s), regardless of the sincerity of their apology. It appears success is determined by this verbal confession and the client is coerced into being accountable. Somehow, the facilities and the community supporters have seemingly deemed this to be an admirable approach: coercing the coercer.

The clients who have been court-ordered to BIPs that utilize the Duluth Model are coerced into believing that their abusive behavior is simply a choice. The offender's circumstances are deemed irrelevant and of no causal value to his current behavior, in fact, if it deviates from the framework within the Duluth Model, it is viewed as resistance, and therefore not tolerated (Corvo et al., 2009). Offenders are "taught" how to stop using power and coercion by a treatment model that uses power and coercion to force a narrow-minded view in attempt to explain domestic violence. This coercive atmosphere within the Duluth Model share many common characteristics that accompany an abusive relationship. For example, an abusive relationship involves shaming and name-calling. Ironically, the standard practice of IPV intervention begins by using a derogatory name for its offenders; "batterer." No other treatment programs refer to their clients by their behavior. Labeling a client by a derogatory name is unethical and does not constitute best practice. In fact, it seems to be a double standard, since offenders are expected to confront their verbally abusive behaviors, such as name calling (see Table 1).

TREATMENT INTEGRITY

Evidence-based practice (EBP) has become an important part of treatment standards for most mental health fields (e.g., psychology, social work; Thyer, 2004). According to the American Psychological Association (2005), EBP's core principle is to conduct

informed practice based on an understanding and use of the best available scientific research findings. Practitioners can best achieve success when conforming to EBP standards by implementing interventions with treatment integrity. Treatment integrity or fidelity focuses on the accuracy and consistency with each component of how a treatment plan is delivered and evaluated (Andrews, 2006). Taking the existing literature one step further, we bring to question yet another ethical concern; that treatment integrity has yet to be explored in the realm of batterer intervention, at least to the best of our knowledge.

Identifying an effective treatment plan is the first step toward providing a client with the best opportunity for successfully modifying their behavior. Comparatively, it is equally as critical that the treatment plan be implemented as designed for that particular client. Treatment integrity (or fidelity) reflects the accuracy and consistency of each component of a treatment plan (Andrews, 2006). From the counselor and/or facilitator's perspective, it sets a standard of expectations for the counselor and/or facilitator. One may even say it is a means of accountability for the mental health professional. Treatment integrity not only strengthens the treatment outcome, it also provides an opportunity for direct support and performance feedback. This could be especially useful in the field of IPV intervention, as research shows that most facilities using the Duluth Model are led by paraprofessionals who receive training that is only relevant to the model's core values (Pender, 2012).

OUTCOME EVALUATIONS OF "BATTERERS" INTERVENTIONS

The question of whether Duluth-type interventions may violate the professional ethics of mental health professionals emerges directly from what has become incontrovertible evidence of their ineffectiveness. No longer seriously in question, Duluth-type interventions are known to have little to no effect on domestic violence perpetration (Dutton & Corvo, 2006, Eckhardt, Murphy, & Whitaker, 2013).

In spite of these consistent findings (Bohall et al., 2016; Corvo et al., 2009; Herman et al., 2014; Radatz & Wright, 2016), the standard Duluth-type model of intervention with "batterers" has not been subjected to the same kind of critical reformulation that many other behavioral change programs receive. Rather, program content and protocols, once adopted, are maintained by fixed standards or guidelines developed and disseminated by the domestic violence certifying agencies that are relatively impermeable and unresponsive in regard to program evaluation data. Maiuro, Hagar, Lin, and Olson (2001) found that most states do not require, or even recommend, reviewing new knowledge in the field for possible revision of standards.

EXISTING STATE STANDARDS FOR PERPETRATOR PROGRAMS AND SERVICE PROVIDERS

Upon review of BIP state standards across the United States, Maiuro and Eberle (2008) found that, despite significant debate about the utility of such standards, 45 of the 50 states currently have standards for BIPs written into legislation. There are

only 5% of these states that rely on EBP approaches for IPV perpetrator interventions (e.g., cognitive behavioral models). The five states that do not have any legislative standards for perpetrator treatment are Arkansas, Connecticut, Mississippi, New York, and South Dakota. The fact that this model is still being utilized by 95% of court sanctioned IPV interventions, despite its lack of scientific evidence, is problematic to say the least (Bohall et al., 2016).

Results also indicated that 75% of states were operating under the philosophical framework that IPV stems from patriarchal factors of power and control (Babcock et al., 2016). Ninety-one percent of these states mandate one uniform treatment for all clients, regardless of any individual needs or etiology (Maiuro & Eberle, 2008). Notably, this type of uniform treatment's effectiveness has been criticized, with evidence suggesting that heterogeneous and specialized treatments may be more effective in preventing future violence (Cantos & O'Leary, 2014).

Mental health providers, particularly practicing licensed professionals, are held to a higher ethical standard of practice than nonprofessionals, paraprofessionals, and volunteers who may be involved with BIPs (Babcock et al., 2016; Corvo & Johnson, 2003). That higher standard is embodied in the various professional codes of ethics, as well as the greater expectation for competency that professional education and licensure carry. This means that practitioners with graduate degrees and professional licenses are subject to the consequences of unethical practices. However, those licensed professionals (e.g., psychologists, social workers, etc.) who provide Duluth-type services to IPV perpetrators are engaging in a form of practice for which the predominant body of evidence finds no positive effects on violent behavior, therefore potentially violating the ethical standards of their license. Thus, the nature of trained counselors may be incompatible with the treatment modality currently mandated with the Duluth Model.

DISCUSSION

Within the framework of this literature review, we aimed to explain the overall expectations of BIPs as we compared and contrasted the Duluth Model with EBP. The following potential ethical concerns are as follows:

Failure to Consider and Utilize Research Evidence

The American Psychological Association states that the core principle surrounding EBP is understanding the best available research findings to better inform practice, thus, delivering more effective treatment. The research has been forthcoming of the Duluth Model's lack of evidence-based findings. However, it is unclear why it is still being used predominantly today (see Table 2). The impact of domestic violence clearly goes beyond its victims if state officials, who claim to be in office to protect citizens, are flat out ignoring one of the most dangerous threats to their constituents (Corvo et al., 2009). Again, where is the integrity? A question may be, why even have ethical guidelines if they don't apply to all, for all?

Failure to Ensure Treatment Integrity

Most states do not require, or even recommend, reviewing new knowledge in the field for possible revisions of standards (Maiuro et al., 2001). Moreover, most states do not engage in program evaluations of BIP efficacy. This lack of investment not only raises a multitude of questions of accountability, it brings ethical concerns of a seemingly faulty system.

Inadequate Assessment/Diagnosis

An accurate and fair assessment plays a vital role when developing adequate treatment designs that are client-specific so that appropriate interventions may be established. There are several known risk factors for IPV perpetrators (e.g., personality disorders, insecure attachment, dependency, trauma, alcohol problems/addiction, dysfunctional anger, emotional dysregulation, etc.) (Cameranesi, 2016) that should be considered during assessments. Several of these IPV risk factors are diagnosable under the guidelines of the *DSM–V*, yet BIPs fail to understand, or refuse to acknowledge, the link these risk factors can have in IPV perpetration. Instead, they create and assign their own labels of "batterer" or "abuser" as a means of fitting the perpetrators to the treatment, rather than tailoring the treatment to the perpetrator.

In more recent literature, non-IPV corrections populations have implemented more evidence-based assessments based on the risk–need–responsivity (RNR) model. The RNR Model allows a more heterogeneous approach for individual clients as it determines both the length and intensity of treatment in accordance with the client's risks and criminogenic needs. RNR considers culture, learning style, gender, sexual orientation, and the relationship between the counselor and/or group facilitator (Hamel, 2019). This model has been pivotal in the development of more adequate assessment tools, such as the Domestic Violence Risk and Needs Assessment used in Colorado (Gover, 2011).

Colorado classifies offenders into one of three levels of treatment: low, medium, or high intensity (Gover, 2011). The risk factors that determine the offender level are: prior domestic violence charges or incidents, drug and alcohol abuse, mental health issues, suicidal/homicidal ideation, access to firearms or threat/use of a weapon, criminal history, obsession with the victim, safety concerns, violence and/or threatened violence toward family members, attitudes that support or condone spousal assault, victim separated from offender in the last 6 months, unemployed, and absence of verifiable social support. Through accurate assessment and more corresponding treatment, there is a greater chance of reduced recidivism. It would make sense that a low-intensity treatment would be more educational, whereas a high-intensity treatment would include crisis intervention and offender stabilization. Thus, tailoring the treatment toward the client's needs seems to be much more helpful, ethical, and dignifying.

In addition to the promising advances with Colorado's legislation, Washington State now has state standards for treatment requirements for IPV offenders. Much like Colorado, Washington State requires an offender assessment to determine level

of risk, needs, and responsivity for the participant. The process must include: a behavioral assessment and screening interview, collateral information from third-party sources, legal history, a summary of all applicable evidence-based, objective standardized tests. The assessment process is ongoing throughout treatment and makes changes if deemed necessary. These guidelines also offer a detailed view of requirements for each staff member who may conduct any offender assessment or serve as the group facilitator. Washington State only allows for qualified clinicians with significant training and experience to conduct assessments and/or facilitate IPV group therapy (WAC 388-60B-0110). The future of IPV treatment would be wise to refer to these detailed and necessary guidelines.

Failure to Provide Individual Treatment Appropriate to Client's Needs

The Duluth Model was developed during the feminist movement and was tailored toward advocating for justice of female victims of partner abuse (Babcock et al., 2016; Bohall et al., 2016; Brasfield, 2014; Cameranesi, 2016; Healey, 1998; Pence & Paymar, 1993). Thus, it could be argued that this model was created from a position of bias. Being that both victim and offender need adequate care, it would be sensible to provide that care separately, in an unbiased environment. Thus, both entities should not be served by the same group if effective change is the desired outcome.

Using a Diagnosis Not Identified in the *DSM–V*

While the term batterer and/or abuser is used as a commonality in BIPs, there is no actual diagnosis identified nor a named condition in the *DSM–V* for those who display abusive behavior (Dutton, 2007). It is rather perplexing to witness advocates against IPV (e.g., Duluth Model creators) shaming and dehumanizing the offenders as if that will cultivate a society free from abuse. One may wonder if these advocates are aware of the deficit in their treatment modality. Furthermore, it is somewhat disappointing to question the integrity of the thousands of BIP facilities who market themselves to an already vulnerable and delicate population, since they continue to use an ineffective treatment model.

Giving a Diagnosis Without Proper Credentials or Client Evaluation

Considering the complexity and severity of IPV, this population should be treated by qualified professionals. Administering and scoring risk assessments for the likelihood of future violence often requires graduate-level training, and extensive experience in interpreting measures. As it currently stands, BIPs operated by paraprofessionals may not be well equipped in this domain. This seems to only be doing further disservice to those receiving this type intervention.

Imploring a Homogeneous Approach to a Complex Behavior

Literature suggests that IPV offenders are a heterogeneous population consisting of varying types of violence, and each subgroup responds to a different type of therapy

(Bohall et al., 2016; Holtzworth-Munroe & Stuart, 1994). These varying types of subgroups are complex and should not be approached with a homogeneous treatment. To do so would be as sensible and ethical as treating every individual who displays symptoms of depression with electroconvulsive therapy (ECT) when they require different modalities of treatment.

Suggested Treatment Approaches

Research on psychoeducational models has been shown to improve an individual's knowledge but has little to no impact on changing problematic behaviors. Although, psychoeducation focuses on strengths and how to further prevent problems, it does not provide remediation of behaviors, such as emotional dysregulation, poor impulse control, or substance abuse (Lukens & McFarlane, 2004).

Psychoeducational programs that integrate a motivational interviewing (MI) component have shown promising results. Many empirically supported alternative treatment approaches have been suggested throughout the literature. Studies by Stuart et al. (2003) and O'Farrell, Fals-Stewart, Murphy, and Murphy (2003) found that treating alcohol addiction in and of itself decreased IPV to a much greater degree than what is found within the framework of Duluth-type interventions.

The more recent IPV research has a large focus on trauma-informed treatment, being that many of the IPV offenders with severe emotional dysregulation have significant histories of trauma that should not be ignored. Trauma symptoms in IPV perpetrators are correlated with greater severity of abusive behavior, more intense relationship dysfunction, more susceptibility to substance abuse, and greater risk for generalized violence. These findings highlight the need for intervention approaches that are sensitive to the potential effects of traumatic stress among IPV perpetrators (Taft, Murphy, & Creech, 2016).

The literature makes it clear that IPV perpetrators are not a homogeneous group. These findings indicate that differential treatment placement in intervention groups would allow for more individualized care based on the type of violence, involvement with substance abuse, mental illness, or personality. Therefore, programs that acknowledge the individuality of the client and personalize treatments specific to their idiosyncrasies tend to be more successful. This begs consideration in order to better tailor treatments toward the individuality of the clients and their specific needs.

CONCLUSION

There appears to be a lack of a socially acceptable process for individuals who have engaged in violent behavior to seek treatment. The restriction of appropriate language that is acceptable to ask for help makes it difficult for someone who is engaging in abusive behavior to feel safe enough to reach out to change their toxic behaviors. Furthermore, there seems to be a lack of identifying abusive behaviors directly. The language often heard concerning abusive behaviors are typically referred to as "anger

issues," "attention seeking," or "control issues." Community acceptance approaches encourage accepting people beyond their behavior, thus, caring for the person more than the offense.

Beyond the community level, practitioners must be willing to hold themselves accountable for the treatment they choose for their clients. If state standards are not concerned with efficacy, recidivism, or implementing change, then the mental health providers must be willing to *be* the change. Providers in the mental health field are to honor, above all else, the ethical guidelines of the license or credential they hold. It may be unethical to deliver a model of treatment to a client that is known to be ineffective.

Mental health providers, particularly practicing licensed and/or credentialed professionals, are held to a higher ethical standard of practice than nonprofessionals, paraprofessionals, or volunteers who may be involved with BIPs (Corvo et al., 2009). This means that practitioners with graduate degrees and professional licenses are subject to the consequences of unethical practices. Interestingly, those licensed professionals who provide Duluth-type services to IPV perpetrators are engaging in a form of practice for which the predominant body of evidence finds no positive effects on violent behavior, and are, therefore, possibly violating the ethical standards of their license. We propose that implementing treatment integrity would help aid in the improvement of BIPs. Treatment integrity would raise the standards of quality care, it would allow more mentorship-style relationships in the workplace, and more importantly, it would hold mental health professionals accountable for their therapeutic approach.

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Correspondence regarding this article should be directed to Ashley LeBlanc, University of Southern Mississippi, Gulf Coast, 730 E. Beach Blvd, Long Beach, MS 39560, USA. E-mail: anleblan@my.loyno.edu

APPENDIX A

TABLE 1. Comparison of Abusive Relationship and Duluth Model Treatment

	Abusive Relationship	Duluth Model Treatment
Accountability	Partner takes no accountability for abusive behavior and/or harm caused to victim	Takes no accountability for its ineffectiveness
Coercion	Partner intimidates victim into conforming to beliefs, rules, expectations. "My way or the highway!"	Intimidates client into conforming to beliefs, rules, expectations of the model. "Our way or the highway!" (aka jail)
	Victim often times will fear worse conditions if noncompliant	Client often times feel trapped because noncompliance results in jail time
Gaslighting	Partner minimizes and denies abuse, blames the victim for the abuse, rejection from partner, manipulation, intimidation, isolation, threats, coercion, ignore needs of the victim.	Model minimizes and denies his own victimization of abuse, blames client for abuse entirely, client feels rejected and judged, manipulated into acting a certain way to achieve completion of the program.
Neglect	Needs are neglected (e.g., physical, emotional, mental, safety)	Needs are neglected (specific care, emotional, mental, possible addiction)
Shame	Shameful labels (name-calling), false identity, put-downs, demeaning, and humiliating	Shameful labels (abuser, batterer), false identity ("this is why you do what you do."), put-downs (minimizing effects from his past that may contribute to his abusive behavior)
Loss of autonomy	Victim loses voice due to partner control	Client loses voice because any feelings are viewed as an excuse
Financial abuse	Partner uses money to exert power and control over the victim	Client is forced to pay for services and time off work to participate in an ineffective program
Deception	Partner presents himself as a wonderful guy in the beginning	Client and partner are deceived when they are given false hope of treatment efficacy

APPENDIX B

TABLE 2. Duluth Model Values Versus IPV Literature

Duluth model	Abuse is a choice and abusive people can choose not to abuse	Abuse is housed in male dominance and privilege and is used as a source of power and control	Psychoeducational model	Homogeneous approach—narrow, inaccurate "one size fits all" approach	Behavior is the problem and the main focus	Uses paraprofessionals	Demands accountability—regardless of dynamics	Labels and shames clients with a derogatory name—all are batterers	Coerced to adopt Duluth values regardless of whether they agree
Literature	Abuse has several risk factors, including, personality disorders, insecure attachment, dependency, paternal rejection, trauma, alcohol problems/addiction, dysfunctional anger, emotional dysregulation.	Abuse is linked to the suggested theories of social learning model, family systems model, and psychosocial theory.	Treatment must target the specific needs of each individual. Psychoeducation, alone, is not effective as it is used to inform clients when they have a desire to learn about their condition. When it is not used alongside a therapeutic approach, it has no effect on behavior.	Heterogeneous population with varying typologies, severity of violence, and each subgroup responds to a different type of therapy. All are different and complex.	Behavior is a symptom	IPV needs to be treated by qualified professionals	Accountability and change stem from autonomy	No diagnosis or named condition	Therapy must be person-centered and relationship-based