

Beyond gender: Finding common ground in evidence-based batterer intervention

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Understanding power dynamics in intimate partner violence

### Abstract

The effectiveness of batterer intervention programs (BIPs) in reducing rates of intimate partner violence (IPV) has been seriously questioned. Critics charge that these programs fail to meet the criteria for “evidence-based practice” because they rely on outdated gender-based models, are not always tailored to client needs, and limited by outdated state standards. Findings are presented from a broad overview of research on IPV and batterer intervention group programs in the general population and among ethnic minority and LGBTQ populations, as well as relevant research on general psychotherapy, self-help and group process research, with implications for improved treatment outcomes. A general framework for evidence-based treatment is proposed, based on Risk-Need-Responsivity (RNR) principles. An emphasis is placed on how front-line providers can find common ground across theoretical perspectives, and meet client needs, by combining clinical experience and client preferences with established empirical research findings. A sound psychoeducational curriculum should address the criminogenic needs, or risk factors, common to all offenders, with emphasis on some factors over others, depending on the client population (e.g., misogyny and gender roles for patriarchal men, poor impulse control and inadequate relationship skills for clients whose violence is mostly expressive or situational). This chapter also highlights the importance of evidence-based, treatment that demonstrates a high level of responsivity – or *how* a program addresses each client’s individual needs and engages them in the group process and helps clients feel respected and understood.

Keywords: batterer intervention, domestic violence, intimate partner violence, perpetrator treatment, gender

### **Introduction: Batterer Intervention Today**

Beginning in the early 1980s, domestic violence, also known as intimate partner violence (IPV), has been recognized as a major social problem in the United States — one that affects millions of families. Initially, individuals arrested on a domestic violence battery charge were almost exclusively male offenders who had committed serious assaults upon their partners. With the introduction of mandatory arrest and “no-drop” prosecution policies, arrests increased as well as the proportion of cases involving lesser offenses. Arrests of female perpetrators increased somewhat before declining once again after victim advocates pushed for “dominant aggressor” guidelines. These guidelines discouraged dual arrests even though the violence among partner-abusive couples is mostly bi-directional (Langhinrichsen-Rohling, et al., 2012), and favored the arrest of males on the presumptions (now known to be false) that women rarely initiate IPV or seek to exercise power and control over partners (Hamel 2011). On the other hand, among same-sex partners, where the parties are more likely than among straight couples to be of similar physical size, the violence is often assumed to be “mutual” when in fact one partner may dominate. Consequently, social service agencies have traditionally misunderstood the problem, and it has been treated as inconsequential, even humorous, by law enforcement and therefore not worthy of criminal arrest (Brown & Groscup, 2009; Letellier, 1994; West, 1998, 2012).

As an alternative to incarceration, intervention programs were established for IPV perpetrators. Known as batterer intervention programs (BIPs), they were grounded in theories linking the cause of men’s IPV primarily to patriarchal attitudes and social structures, and the desire of men to control their female partners (e.g., Dobash & Dobash, 1979; Pence & Paymar, 1993); although some BIPs did incorporate findings and principles from the mental health fields including cognitive-behavioral therapy (CBT) (e.g., Sonkin & Durphy, 1997).

## Beyond Gender

The population IPV perpetrators is now a heterogeneous one, yet in most states all adjudicated offenders, regardless of the severity of the crime, are mandated to a same-sex psychoeducational group program for a specified number of weeks (e.g., 52 in California). In a majority of states, couples and family therapy are forbidden with individual therapy a limited option (Babcock et al., 2016). This “one-size-fits-all” approach persists, even though mandatory arrest policies have led to a substantial increase in offenders; many of whom may be less dangerous than those arrested in previous decades, whose offenses are difficult to charge (mandatory arrest policies have led to a 60% decrease in convictions [Hirschel, 2008]), and who may not need the full number of sessions required by law. Conversely, judges often sentence defendants to a minimal course in anger management, when they require more intensive treatment. These flaws in arrest and prosecution policies may explain the minimal impact of BIPs on recidivism rates (e.g., in California, only 50% of individuals mandated to a BIP complete the program [California State Auditor, 2006]).

### **Current Research on IPV**

Critics of domestic violence policy and intervention have long argued that BIPs could be more effective in reducing rates of recidivism among offenders if they were based on the empirical research evidence rather than the feminist/gendered models championed by victim advocates (Dutton, 2010; Dutton & Corvo, 2006). According to results from the National Intimate Partner and Sexual Violence Survey (Black, et al.2011; Walters, et al., 2013), rates of both physical and psychological IPV are comparable across gender, and are as high, or higher, among LGBTQ populations as they are among straight couples. Additionally, when controlling for socioeconomic status, IPV rates are similar across ethnic groups (Malley-Morrison & Hines,

2004; West, 2012). IPV, particularly in the United States, is a human problem, not one of gender, culture, or sexual orientation.

There is no doubt that throughout the world, including the United States, patriarchal structures continue to impact women's social, economic, and political well-being, and that many individual men harbor misogynistic attitudes. Clearly, gender equality remains a goal worth championing, but while there is some overlap between the status of women and rates of IPV, these should be considered separate problems. Even in non-Western industrialized countries, the impact of patriarchal structures (based on the United Nations Gender Empowerment Measure designed to determine the relative empowerment of women across countries) on rates of male-perpetrated IPV are not clear-cut (Esquivel-Santovena, et al., 2013). Furthermore, Sugarman and Frankel's (1996) meta-analysis found correlations between physical abuse and attitudes condoning such violence; however, traditional gender role attitudes did not differentiate non-violent men from those who abuse their partners. As pointed out by Felson (2002), societal power does not automatically translate to personal power. Gendered models, of course, also fail to account for the high IPV rates found among lesbians, and may reinforce common stereotypes about this population, e.g., that perpetrators are necessarily "butch," and are acting "like a man."

Findings from a series of literature reviews (Hamel, et al.2012)<sup>1</sup> support the viability of individual, couples, and family counseling as an alternative or adjunct to the group format; and the high level of symmetry across gender in the rates of physical and psychological abuse/control, motivating factors, and the causes, characteristics, and dynamics of IPV (see Table 1), calls into question the ubiquity of Duluth and similar gender-based interventions —

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<sup>1</sup> The Partner Abuse State of Knowledge Project (PASK), can be accessed by anyone for free at [www.domesticviolenceresearch.org](http://www.domesticviolenceresearch.org), and consists of 17 articles (2,657 pp.) previously published in 5 issues of the peer-reviewed journal, *Partner Abuse*

## Beyond Gender

interventions that might be more effective if applied to selected populations rather than part of a one-size-fits-all curriculum.

While the relative importance of gender roles/patriarchy as risk factors for IPV continue to be debated, there has been greater consensus about those most associated with the perpetration of physical and emotional abuse. They include; stress from low-income or unemployment; having an aggressive personality; including pro-violent beliefs; poor impulse control and anger management problems; alcohol and drug abuse; being in a high-conflict/abusive relationship; and having experienced violence/dysfunction in one's family of origin. With minor exceptions, risk factors were found to be the same across gender (Capaldi, et al., 2012), with homophobia is an additional risk factor in LGBQ relationships (Letellier, 1994; West, 1998).

**Offender types.** In the typology by Holtzworth-Munroe and Stuart (1994), male perpetrators can be broadly categorized into three types. The first, the *family-only* types (estimated to account for about half of the IPV offender population), are regarded as the least dangerous with low levels of psychopathology and less serious domestic violence histories. About 25% of the offending population are the second type of offender, what the authors call *dysphoric/borderline*, and consist of men with characteristics of borderline personality disorder (BPD), often suffering from depression, who are typically not violent outside the home but who have very poor impulse control, tend to be emotionally insecure, are controlling and possessive, and are capable of serious, injury-producing violence. Finally, the men categorized as *generally-violent/antisocial* account for the rest of the offender population. In contrast to men in the other categories, they have engaged in criminal activities including interpersonal violence outside the home. They are extremely impulsive and highly dangerous, frequently abuse substances, and are controlling of their partners. In contrast to borderline men, their attachment style is dismissive

## Beyond Gender

rather than preoccupied (clingy). Similar categories have been found among populations of female offenders as well (Babcock, et al., 2003).

As mentioned previously, partner violence is more often than not bidirectional (Langhinrichsen-Rholing et al., 2012), thus limiting the usefulness of typologies such as Holtzworth-Munroe and Stuart's which focus on the characteristics of only one party in a relationship. The model put forth by Johnson (2008) sought to reconcile survey data showing comparable rates of violence between the sexes and findings from clinical populations that pointed to greater asymmetry in frequency and severity of IPV. While critics have called into question some of Johnson's conclusions regarding rates of serious IPV perpetration across gender (e.g., Bates, Graham-Kevan, & Archer, 2014; Jasinski, et al., 2014), the typology proposed has been helpful in identifying the treatment needs of a heterogenous offending population (e.g., Hamel, 2014; Potter-Efron, 2005). In particular, individuals who engage in controlling/coercive abuse fit the pattern of behavior characteristic commonly known as *battering*, which implies a long-standing use of physical, psychological, and sometimes sexual abuse to dominate one's partner that tends to escalate over time and is more likely to lead to life-threatening injuries. The partners of these offenders may or may not be abusive themselves.

In comparison, the majority of relationship abuse is less frequent or consequential. Johnson's term for this type of abuse, *situational violence*, reflects a reactive dynamic of escalating conflict and emotional expression in contrast to more conscious attempts by a partner to dominate and harm the other. Rates of both situational and controlling/coercive abuse are comparable across gender (Jasinski et al., 2014). Although formal typologies have not yet been formulated for LGBTQ offenders, there is evidence from various studies that the violence in a majority of this population, like heterosexual IPV offenders, is situational, driven by escalated

## Beyond Gender

conflict attachment insecurity (e.g., Bartholomew, et al., 2008; McKenry, et al., 2006). More consequential violence among LGBTQ perpetrators closely resemble the various battering patterns found among straight populations (e.g., Walker's three-phase cycle, PTSD among victims, extreme jealousy and personality disorders on the part of the perpetrator), although some forms of controlling behaviors (e.g., threatening to "out" one's partner) are specific to the LGBTQ community (see Coleman, 2002; Hamel, 2014 for further discussion).

### **Primary BIP Treatment Models**

**Duluth.** The most well-known and imitated model for IPV group intervention regards the primary cause of IPV to be patriarchal social norms that presumably support male privilege, and beliefs held by men that they can abuse their partners to maintain male dominance over women (Pence & Paymar, 1993). In a highly structured group format, male participants are educated about the nature of the patriarchal actions they use to control women such as intimidation, isolation, and economic abuse, and to foster an egalitarian mindset. The program is not considered to be "treatment," but an opportunity for perpetrator re-education that subsequently comprises merely one component in the broader community-wide response to IPV.

**Cognitive-Behavioral Therapy (CBT).** In this model, IPV is believed to be rooted in distorted thinking about self and partner, and the utility of violence to dominate or to resolve problems. It addresses all relevant risk factors including childhood-of-origin violence and dysfunction; aggressive personality; poor emotion management and interpersonal functioning; and substance abuse. Main intervention components include strategies that target thoughts, emotions, and behaviors through a mixture of psychoeducation, discussion, homework assignments, and cognitive reframing. Interpersonal deficits are targeted through a skills training approach (e.g., Murphy & Eckhardt, 2005; Sonkin & Durphy, 1997; Wexler, 2000).



**Process/Psychotherapeutic.** Intimate partner violence, according to this view, 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. Long-term desistance is more likely when a client addresses these emotional and social issues, is empowered to get his or her needs met, and has achieved a positive sense of self. There is less of an emphasis on didactic presentations; 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 (Bowen, 2009; Stosny, 2004, 1995).

### **Controversy and Mistrust**

Over the years, the author has observed that among the various stakeholders involved in IPV policy — intervention and treatment — some regard IPV as a social and behavioral problem while others regard IPV more as a mental health issue. The first group (mostly consisting of law enforcement, victim advocates, and some batterer intervention providers), would argue that focusing on anger, trauma, or substance abuse prevents clients from taking responsibility. Their indoctrination in the gender paradigm makes them wary of the term “evidence-based,” which implies therapeutic interventions best suited for the general population. Instead, they value the experiences of the victims and favor Duluth or other feminist-psychoeducational models. The second group (among them mental health professionals and some batterer intervention providers) rejects Duluth as unscientific and contrary to professional codes of ethics (Corvo, Dutton, & Chen, 2009; Corvo & Johnson, 2003; Lee, Uken, & Sebold, 2009). Others have deemed gendered models to be “heterosexist” and inadequate for the treatment of same-sex violence (Letellier, 1994). This unnecessary schism, unfortunately, has limited potentially beneficial cooperation between researchers and providers.

## Beyond Gender

In this chapter, an attempt is made to establish common ground among all stakeholders from the perspective of a scholar-practitioner. Areas of core agreement will be proposed, such as the importance of client engagement to prevent drop-outs or the acquisition of pro-social skills. The importance of gender equality and the rights of LGBTQ individuals can be agreed upon, without the presumption of misogyny among all male perpetrators. Given that relationship conflict is a known IPV risk factor, gender roles and gender differences can be a legitimate focus of treatment for many clients, without the cumbersome and potentially alienating theoretical architecture of gendered intervention models that fail to address both LGBTQ and female-perpetrated abuse. Front-line providers, it will be argued, can better meet the needs of their specific populations by combining clinical experience with established and promising empirical research findings drawn from a broad overview of BIP research, as well as relevant research with other populations including general psychotherapy clients, correctional populations, and individuals active in 12-step and other self-help programs. But first, it is crucial that the term “evidence-based practice” is properly defined.

### **Evidence-Based Practice**

To improve BIP outcomes, intervention providers should be familiar with the full range of available treatment options, including the research evidence. The American Psychological Association defines “evidence-based practice” as the “integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences” (APA Presidential Task Force, 2006, p. 273). Given the practical limitations of an average agency conducting randomized control outcome research, can a program be “evidence-based” if it is simply modeled after one that has been found effective under the strictest methodological research designs? If so, how far can it deviate from its model and still meet the needs of a

## Beyond Gender

potentially different client population? Before these questions can be answered, two major obstacles must be overcome. The first is the existence of state standards regulating BIPs in the United States that emphasize gendered treatment models advanced by victim advocates (Babcock et al., 2016; Maiuro & Eberle, 2008) with limited applicability to a broader range of clients. The second obstacle lies in the subjective biases inherent among some intervention providers, especially those without professional licensure or unfamiliar with research methodology.

### **Problem of Bias and Subjectivity**

After three decades conducting and supervising BIPs for court-mandated perpetrators in the San Francisco Bay Area and having regularly met with BIP colleagues, it is the author's impression that most providers genuinely care about their clients and believe they are doing the best they can to help them take responsibility for their violence. However, upon what empirical basis do they assume that their programs are effective in reducing rates of physical and emotional abuse? Upon what empirical basis are they certain that their treatment model is appropriate for the clients they serve?

According to the American Psychological Association (APA), "integral to clinical expertise is an awareness of the limits of one's knowledge and skills and attention to the heuristics and biases — both cognitive and affective — that can affect clinical judgment" (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 276). Among the more common of these are the *availability heuristic*: estimating an outcome on the basis of how easily we can imagine that outcome occurring (e.g., most of our clients are men, so we view them as perpetrators and women as victims); the *representativeness heuristic*: evaluating something as belonging to a category based on superficial reasons (e.g., all

## Beyond Gender

offenders are labelled “batterers,” implying that they all have demonstrated a pattern of serious violence and power/control); and *confirmatory bias*: the tendency to seek information that would confirm our expectations. In a remarkably courageous act of humility, the late Ellen Pence, co-founder of the Duluth model observed:

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)

Research on the effectiveness of psychotherapy indicates that treatment outcomes improve when therapists dedicate themselves to ongoing learning and self-examination. One meta-analysis found that it is not the number of years of clinical experience, per se, that predict treatment outcomes, but rather time devoted to improving one’s therapy skills (Tracey, et al., 2015). A survey of psychotherapists (Vollmer, et al., 2013) had previously found that clinical knowledge typically increases throughout the period of postgraduate training and then stops. Unless a clinician makes it a point to continue the learning process beyond this, his or her skills may decline, thus reducing treatment flexibility and compromising outcomes. These findings would

## Beyond Gender

certainly apply to those batterer intervention providers who lack adequate education in psychology and mental health counseling.

### **Research on BIPs**

The term “evidence-based practice” can be defined in various ways. From a social work perspective, it is 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” (Shlonsky & Gibbs, 2004, p. 137). Elements of this “systematic” process, however, are not equally valuable. Clinical observations are thought to provide the least reliable types of empirical data whereas randomized clinical trials (RCT) are considered the gold standard.

Outcome research with similar populations (e.g., substance abusers, correctional populations) can also be useful, setting the stage for more formal research on IPV and may inform interventions where more methodologically-sound research is unavailable. But there does exist a body of batterer intervention outcome research based on RCT and quasi-experimental designs, and this is where we must begin if we are to define, promote, and implement evidence-based intervention policies.

One of the first meta-analyses of the BIP outcome literature (Babcock, et al., 2004) found minimal effect sizes, ranging from  $d = .01$  (from more reliable victim reports) to  $d = .26$  (from less reliable police records that do not capture unreported assaults). Effect sizes of .2 and under are considered low. A  $d$  of .5 is considered moderate, and .8 is a large effect size. Based on partner reports, court-mandated perpetrators have a 60% chance of being successfully nonviolent following court monitoring and completion of a batterer intervention group. However, their chances without group treatment are 55%: an improvement of only 5%. In comparison, the

## Beyond Gender

average effect size for general psychotherapy is  $d = .85$ , indicating a 40% improvement over no treatment. Effect sizes are also higher for adolescent aggression treatment ( $d = .32$ ; 16% improvement), and adult correctional treatment ( $d = .25$ ; 12% improvement).

As part of the Partner Abuse State of Project series of literature reviews, cited earlier, Eckhardt and his colleagues (2013) identified 8 RCTs and 12 quasi-experimental studies of traditional BIPs (Duluth, CBT, or Process/Psychotherapeutic). Some involved a comparison of treatment to a no-treatment condition, and others compared one treatment to another. The authors reported significant positive outcomes (reduced rates of recidivism) in 9 studies, of which 8 used a less rigorous quasi-experimental design. In general, what the outcome literature suggests is that overall effect sizes for group treatment are low, particularly when the data comes from RCT methodology and is based on victim reports. RCT replications have not been conducted on any specific program, and while one review found gender-based models essentially useless (Miller, Drake, & Notzinger, 2013), those found effective (couples counseling and BIP groups for substance abusers) would not be appropriate for many offenders.

One promising treatment model has recently emerged (Zarling, et al., 2017) based on principles of Acceptance and Commitment Therapy (ACT), a form of CBT that includes mindfulness, emotion management, relationship skill-building, and values-directed goals. Clients, who had been referred from mental health clinicians and who had perpetrated at least 2 physically aggressive acts toward their current or former romantic partners within the past 6 months, were randomly assigned to a 12-week ACT or a support/discussion control group. At a 6-month follow-up, ACT clients had perpetrated significantly less psychological and physical partner aggression. Replication studies are now underway. Remarkably, no RCT studies have yet been conducted with female perpetrators, nor with those who identify as LGBTQ.

**Reasons for minimal BIP effectiveness.** Some observers (e.g., Gondolf, 2011, 2012) suggest that the effectiveness of standard feminist and/or CBT programs is understated and cite larger effect sizes from quasi-experimental designs that take into account confounds due to unmeasured client characteristics (Gondolf, 2012). These claims, however, remain controversial. There is no doubt that some RCT studies have been tainted by methodological problems – for instance, assignment to conditions is not always random, the treatment model is not always clearly defined, and making comparisons across models (e.g., between CBT and Duluth) is difficult at best. Effects are also diluted from heterogeneous samples subjected to a “one-size-fits-all” treatment, and research has mostly focused on the effectiveness of one theoretical model compared to another rather than determining what works and building programs around these findings. This will be explored in an upcoming section.

***Findings from a National BIP Survey.*** It might be worthwhile to pause and remember that, especially in the absence of clear, replicated experimental outcome findings, clinical experience may yield useful data. This was the rationale for the 15-page questionnaire, the North American Domestic Violence Intervention Program Survey (NADVIPS), sent in 2016 to BIP directors in U.S. and Canada (Cannon et al., 2016). Questions were asked about program characteristics (e.g., populations served, treatment approach, facilitator training and education, relationship with victim advocates, law enforcement and other community organizations), as well as questions intended to gauge facilitator knowledge about IPV rates of perpetration, abuse dynamics, and views on intervention policy.

Surveys from a total of 238 respondents were completed, providing both descriptive and analytic data. Based on this convenience sample, it appears that batterer intervention providers in the U.S. and Canada are, for the most part, well-educated (almost half have a Master’s degree),

## Beyond Gender

trained (30 hours IPV training annually), and experienced (average 8 years). The primary or secondary treatment approach for 47.3% of BIPs is Duluth, and 54% for CBT. The majority of programs provide standard information on power and control behaviors and the effects of domestic violence on children as promulgated by feminist theory, but also teach a variety of well-established emotion-management and relationship skills common to CBT. A variety of interventions are utilized, including hand-outs and exercises, role-play and digital media, as well as “check-in” time for general discussion. When asked about ways to handle typical problems that arise in a group setting (e.g., resistance, interruptions), respondents provided clinically-sound recommendations. The average program intake is conducted over 1.5 hours — a reasonably adequate amount of time with which to properly assess a new client. In light of poorly written standards in most states (Maiuro & Eberle, 2008), a sizable minority of providers (40%) are willing to work outside these standards or supplement them when necessary.

Not all responses were as promising, however. When asked to identify the most significant IPV risk factors, 85% identified “need for power and control” as the most important, but only about one third identified having an aggressive personality or being in an abusive relationship. Additionally, only 22% of respondents identified stress from unemployment or low income as a factor. Moreover, they tend to wrongly assume men primarily initiate psychological and physical abuse typically motivated for reasons of power and control, in contrast to female offenders whom they believe are violent in self-defense. Furthermore, Chi-square analyses indicated less educated facilitators to be more inclined to view patriarchy as cause of domestic violence, to be misinformed about motivation factors, and to spend less time conducting assessments.



With respect to LGBTQ clients, most respondents found work with this population to be challenging. Facilitators noted that these clients had difficulties feeling safe and talking openly about their issues in group. While some respondents indicated that they strived to address the particular needs of LGBTQ offenders (e.g., adding to the curriculum, seeing clients individually, reaching out to the broader LGBTQ community), others either said that it would be “unrealistic” to provide specialized services (Cannon et al, p. 249). These findings are not surprising, given that in only about a half-dozen cities are specialized groups for gay or lesbian offenders even available. Although Coleman (2002) has promoted the group format for lesbian batterers and has well-described the features of her own psychodynamic approach, there appears to be a complete absence of outcome studies for the LGBTQ offender population (see Hamel, 2014).

**BIP standards recommendations.** A few years ago, 17 experts on IPV intervention were asked by the editors of the peer-reviewed journal, *Partner Abuse*, to contribute to an exhaustive, up-to-date literature review on the characteristics and efficacy of BIPs (Babcock et al., 2017). Based on this review, the authors arrived at several important conclusions, and made various suggestions to advance evidence-based practice:

- Offenders should be held accountable, and this 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 that specify modality or treatment models.

## Beyond Gender

- Treatment should be based on current best practices informed by empirical research on treatment outcome, treatment engagement, and risk factors for IPV recidivism.
- Risk factors that should be emphasized in a psychoeducational curriculum should depend on their significance for the particular client population and the skills they require – e.g., confronting patriarchal attitudes for misogynistic men; teaching anger management and relationship skills for clients with poor impulse control.
- Length of treatment is not necessarily related to outcomes
- No evidence exists to mandate same-gender group composition. Some individuals are more comfortable sharing with members of the same sex, while others benefit from the diversity inherent in mixed-gender formats.
- 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.

With these general recommendations as a guide, we now examine in greater detail the treatment strategies most likely to lower IPV perpetration.

### **Treatment Strategies for IPV Reduction**

**Risk-Need-Responsivity Model.** The essential components of what researchers consider to be “evidence-based” or “best practices” are implicit in the Risk-Need-Responsivity (RNR) model — popular among providers of interventions with non-IPV corrections populations (Bonta, 1996; Stewart, Flight, & Slavin-Stewart, 2013). The core components are that the length and intensity of an intervention be based on the risk posed by the individual’s acting-out behavior to others and that the intervention addresses the client’s basic criminogenic needs. In batterer intervention, those include all of the risk factors previously discussed. The responsivity

## Beyond Gender

component considers the client's individual characteristics and preferences, culture, learning style, relationship to counselor/group facilitator, as well as gender and sexual orientation. This last component of RNR is crucial for treatment success, as we will see when we explore the BIP and general psychotherapy outcome research in the next section.

**Considerations in differential treatment.** RNR would seem to be a promising model for batterer intervention policy, but as with all theories, its ultimate value will depend on how it is applied and with what populations. Within the general psychotherapy client population, there is evidence for the usefulness of both CBT and psychodynamic models in the treatment of various personality disorders (e.g., Leichenring & Liebing, 2003), and Dialectical Behavior Therapy (DBT) groups for BPD specifically (Fruzzetti & Levensky, 2000). An early study by Saunders (1986) found a process/psychodynamic group more effective in reducing rates of recidivism for male IPV offenders with avoidant personalities; and a Duluth model group better for men diagnosed as anti-social. This study, however, has not been replicated, and one large, multi-site outcome study found no treatment effects based on personality types (Gondolf, 2012). For men with PTSD, trauma models have shown promise (Stosny, 2004; Taft, Creech, Gallagher, Macdonald, Murphy, & Monson, 2016). There is evidence that substance abuse history predicts less client engagement and higher drop-out rates (Ting, Jordan-Green, Murphy, & Pitts, 2009). Therefore, it is not surprising that one RCT study found a substance abuse focus group to be significantly more effective than a traditional curriculum for partner-violent men with a history of chemical dependency (Dunford, 2000).

Eckhardt, et al. (2008) examined group drop-out and recidivism rates in a sample of 199 male offenders and looked for possible correlations to offender type based on Holtzworth-Munroe and Stuart's (1994) typology, as well as client willingness to take responsibility based

## Beyond Gender

on Stages-of-Change theory (Prochaska, DiClemente, & Norcross, 1992). “Family-Only” offender subtypes were more likely to be in the pre-contemplation stage compared to more chronic, severe offenders (e.g., those with borderline traits). On the other hand, “family-only” men were less likely to drop out or recidivate compared to men categorized as Borderline (BD) and Generally-Violent/Antisocial. BD clients in the preparation/action stage of motivation were the most likely to drop out or recidivate probably because of poor impulse control, shame, and other factors needing clinical attention.

From an RNR standpoint, and the “common factors” research discussed in the next section, personality and motivation considerations should always inform how clinicians/facilitators can create a working alliance with each client and maintain a productive group environment. To what extent individuals should be assigned to separate programs based on typology findings has not yet been determined. Until further research is conducted, there is greater support for homogeneous groups based on general risk categories (e.g., low risk versus high-risk; Babcock et al., 2016; Gondolf, 2012). According to Gondolf (2012):

The subgroup of repeatedly violent men doesn’t fit into a neat category. They don’t match a distinct personality type; they aren’t predominantly psychopathic or crazed addicts. Not surprisingly, these men are likely to have more violent and criminal pasts and show evidence of psychological problems — but they do not have a distinguishing profile or profiles...One way to improve batterer program outcomes appears, therefore, to lie in enhancing our response to high risk men — the men who are unresponsive to batterer programs regardless of approach. (p. 170)

It has been long-established that many offenders will not recidivate whether or not they complete a BIP, and most recidivism is perpetrated by a small number of repeat, high-risk

## Beyond Gender

offenders (Maxwell, Garner, & Fagan, 2001). Generally speaking, high-risk offenders share certain similar characteristics. For example, based on arrest reports, a California study (MacLeod, Pi, Smith, & Rose-Goodwin, 2008) found no difference in recidivism across program types, but younger men with longer criminal histories and a history of substance abuse were more likely to recidivate. In general, low-risk offenders are less likely to drop out of treatment compared to high-risk offenders (Gover, et al., 2015). Additionally, drop-out rates are typically lower for court-ordered clients, indicating the importance of cooperation between BIPs and the judicial system (Babcock et al. 2016). However, low-risk BIP clients presenting with minimal levels of anger and marital conflict can be at increased risk of dropping out, perhaps due to minimization of their problems, or when self-referred and placed in groups with high-risk court-mandated offenders (Daly & Pelowski, 2000). Others may also learn to become more violent/manipulative in such groups (Babcock, Canady, Graham, & Schart, 2007).

Efforts have been undertaken in some jurisdictions to implement IPV intervention policies based on RNR principles. In Florida, when adjudicated male IPV offenders were assigned to a low, medium, or high-risk offender group based on a basic risk assessment, recidivism rates were significantly lower than those reported by traditional programs (Coulter & VandeWeerd, 2009). More precise assessment instruments have been developed for IPV treatment based on the RNR model, such as the SARA (Spousal Abuse Risk Assessment) and the ODARA (Ontario Domestic Abuse Risk Assessment) (Nicholls, et al.,2007). Since 2010, Colorado has assigned offenders to differential treatment levels based on the DVRNA (Domestic Violence Risk and Needs Assessment), and the judgement of a multi-disciplinary treatment team. Group is the preferred modality, but more focused, individual sessions can also be mandated with a length of treatment ranging from 26 to 52 weeks for most offenders (Gover, 2011;

## Beyond Gender

Richards, et al., 2017;). Outcome studies have yet to be published, although important data has been collected on issues related to program implementation (Richards, et al., 2015).

Unfortunately, many providers lack the capacity to offer separate groups, whether for low-risk versus high-risk offenders or on any other basis. In some cases, clients may be referred out to an appropriate program. When this is not possible or desirable, it is the responsibility of the provider to address, as best as he/she can, a client's needs. This can be done provided that a program is flexible, and treatment is based on a thorough assessment.

### **Finding Common Ground**

Results of the North American Domestic Violence Intervention Program Survey indicate a large overlap between the major treatment models (Cannon et al., 2016). Providers who cited Duluth as their primary approach tended to cite CBT as their secondary approach, and vice-versa. We have already seen that there is insufficient outcome research showing any model to be clearly superior to another in every case (Babcock et al., 2004). Even if CBT is found to be superior overall, this information does not provide much guidance on how to work with a particular individual. More promising would be for researchers to focus on treatment elements common to all programs, so that providers can develop evidence-based approaches from the "ground up" (Eckhardt, et al., 2006).

### **Overlap Across Treatment Models**

At least among providers, prevailing models are not inherently incompatible. It can be agreed upon that basic human needs such as safety, love and belonging, and self-esteem are universal, and that aggression represents a misguided effort to meet those needs. The extent to which IPV is expressive or coercive can be viewed on a continuum, rather than as rigid binary opposites, as reflected in findings from the 2016 BIP survey (Cannon, et. al., 2016). Critics of

## Beyond Gender

Duluth cite its over-emphasis on patriarchy and misogyny as IPV risk factors, an authoritarian style of group leadership, and an intolerance for dissent that can undermine the facilitator-client relationship and lessen client motivation thereby hindering its overall efficacy (Corvo et al., 2009; Dutton & Corvo, 2010; Stuart, 2005). These are valid criticisms. There is no evidence, however, to indicate that facilitators who work within a CBT or other framework are necessarily more flexible, and common sense would suggest that what some would consider an “authoritarian” style another would deem to be “tough love.” In fact, a primary focus on gender issues would be exactly the type of “evidence-based” approach a misogynist, or someone with rigid gender role beliefs, might very well require. Aside from the ubiquitous “Power and Control Wheel,” a pie-chart description of certain emotionally-abusive and controlling behaviors assumed to be perpetrated solely by men, Duluth uses some of the same interventions as CBT including progress logs, role plays, videos, action plans, and peer support to foster responsibility, respect, honesty, trust, partnership and negotiation, as well as teach skills such as time-outs, sitting down when agitated, and positive “self-talk” (Pence & Paymar, 1993; Miller, 2010).

The Duluth focus on gender and power imbalance is expanded in one program for Latino male batterers, *El Hombre Noble Buscando Balance* (Carrillo & Zarza, 2006), to include broader issues of intergenerational family abuse, insecure attachment, emotional distress, mental health problems, and substance abuse as well as issues of relevance to many Latinos, such as neighborhood violence, poverty and unemployment, acculturation, and IPV as a private family issue (Carrillo & Zarza, 2006). In her own work with abusive Latino men, Welland (2008; 2011) blends a gender-based approach with traditional CBT interventions, including concepts from a manualized CBT program popular in southern California (Wexler, 2000). In the northern part of the state, Sinclair (2015) offers a highly-structured, gender-based, peer-facilitated BIP, *Manalive*,

## Beyond Gender

that resembles Duluth in many ways, but that uses concepts long-established in psychotherapy such as “authentic” versus “false” self. The concept of the “Hitman” (false self) as an abuser’s way to remain violent while avoiding vulnerable feelings is similar to core components of Acceptance and Commitment Therapy: the basis for an emerging approach to batterer intervention found to be effective in reducing rates of recidivism (Zarling, Lawrence, & Marchman, 2015). The Manalive program addresses the effects of childhood abuse and shame-based trauma, and the group encourages compassionate peer support. Its idiosyncratic terminology and scripted rituals are offset with basic CBT skills for emotion management (visualization, relaxation, body awareness) and for what they call “intimating” (“I” statements, validating feedback, setting boundaries, negotiation). Educational material is practiced with examples and role-play.

### **Peer vs Therapist Group Facilitation**

In most states, BIPs are required to be “psychoeducational” in nature, and facilitators are not universally required to be licensed mental health professionals. Unless a group is intended to be explicitly psychotherapeutic, licensure may not be necessary provided that the facilitator has a sufficient level of education and training. As already mentioned, results from one national survey indicate that, on the whole, they are adequately trained and educated (Cannon et al., 2016). In some programs (e.g., Manalive), facilitators are not only unlicensed, but actually ex-offenders themselves. Should this be a matter of concern? Probably not; there is no conclusive evidence to suggest that peer models of treatment are necessarily less effective. For example, research has found Alcoholics Anonymous — a self-help program based on the principle that alcoholics are more likely to stay sober if they work with other alcoholics — to be equally as effective as CBT, relapse prevention, harm reduction, and other models in lowering rates of relapse (Knack, 2009;



## Beyond Gender

McGrady, 1994). Among criminal offenders, recidivism rates are substantially lower for men who seek to share their experiences with others (Maruna, 2001). One BIP outcome study found that a highly-structured Duluth format was more effective than a completely unstructured self-help group. Equally effective, however, was one that combined self-help group processes with education (Edleson & Syers, 1990).

Professional and peer models each have their advantages and disadvantages. For starters, a lack of appreciation for the scientific method and poor research knowledge undoubtedly pose some limitations on peer-led interventions. For instance, A.A. views alcoholism strictly as a “disease” despite evidence for other theories, and an incomplete understanding of the relapse process and the heterogeneity of alcoholic populations may actually undermine an individual’s sobriety (Wiechelt, 2015). In BIPs, incorrect assumptions by peer facilitators about IPV rates, motives, risk factors, and abuse dynamics can lead to resistance and undermine the therapeutic alliance (Cannon et al., 2016). Without professional training, peer facilitators may lack sufficient knowledge in human development, personality, principles of behavior, and learning disabilities thus restricting the facilitator’s ability to properly diagnose or effectively handle mental health issues. Lacking professional accountability compared to licensed therapists, can lead to unproductive counter-transference issues.

Peer models also have their advantages. In A.A., the process of identification allows newcomers to trust and become motivated to change, and sponsors can understand the mindset of newcomers in ways that professionals may not. Similarly, BIP group facilitators can provide a credible example of responsibility-taking. No doubt, having a college degree or a professional license does not automatically confer good judgement that comes from life experiences.

## **Engaging Clients**

## Beyond Gender

The weak evidence for the superiority of any of the major treatment models suggests the use of a common core curriculum based on known risk factors, but one that can also be adjusted in accordance with the needs of a particular population (e.g., culturally-focused groups for ethnic minority and LGBTQ clients, specialized groups for young mothers). Likewise, how such a curriculum is delivered also matters. If peer-led groups can be as effective as those led by mental health professionals, it would seem worthwhile to determine what it is they have in common that contributes to reduced rates of recidivism. Client engagement — the process by which clients are motivated to fully participate in the counseling process and are therefore more likely to change their behavior — appears to be a crucial factor based on both general psychotherapy studies and BIP outcomes studies. BIP completers, according to the comprehensive literature by Daly and Pelowski (2000), are significantly less likely to recidivate than program dropouts.

Motivation is an ongoing concern for professionals working with involuntary clients; as is the case for most IPV perpetrators. Rather than expect cooperation and risk the possibility of unnecessary confrontations with clients, experienced social workers, for example, advise therapists to *expect* resistance which may reflect a mistrust of authority rather than simply denial or unwillingness to change (Jacobsen, 2013). The ability to see the client as capable of change is crucial in establishing a strong facilitator-client alliance and helping clients “buy in” to program expectations (Swift, et al., 2012).

**Psychotherapy outcome studies.** As discussed previously, there has been ongoing tension between IPV researchers and batterer intervention providers who are also licensed therapists on the one hand and victim advocates, law enforcement, and non-licensed batterer intervention group facilitators on the other hand. Such prolonged tension stems from the perceived value of empirical research for batterer intervention. A parallel debate among general psychotherapy

## Beyond Gender

researchers (Horvath, et al., 2011; Wampold & Imel, 2015) centers around the question of defining the essential components of a given psychotherapeutic treatment. Those who adhere to the Medical Model (the belief system that psychopathology is a result of one's physiology) view mental health problems as disorders and their focus is on identifying their cause, the mechanism by which they should theoretically be resolved, and the specific therapeutic procedures for treating them. Just as with diseases and other physical disorders, these procedures are supposed to be formalized and applied consistently.

Mental health and behavioral problems, however, do not always lend themselves to such procedures; thus, therapies with different assumptions about the causes and the course of a disorder can work equivalently. For example, both CBT (with its emphasis on changing cognitions) and a behavioral approach (BA) (one that focuses on changing maladaptive behavioral patterns), are equally effective in treating depression. According to the Contextual Model, one reason for this is that because thoughts, feelings, and behaviors are interconnected, targeting any of these can affect the whole person. Another reason is the importance of common factors across all psychotherapy models. As illustrated in Table 2, outcome research finds the differences between treatments to be minimal compared to the effect sizes of the therapeutic alliance and other common factors (Wampold & Imel, 2015). Still, *something* needs to be delivered, manualized or otherwise, to address whatever risk factors are associated with the problem:

[t]he 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 (Wampold & Imel, 2015; pp. 258-259).

**Engagement in batterer intervention programs.** One of the most exciting findings in BIP outcome research conducted over the past decade or so has been the superiority of Motivational Interviewing (MI): a client-centered treatment approach that incorporates many of the common psychotherapy factors from Table 2. Whether regarded as a distinct intervention model, or as simply a treatment approach that can be used across models, a core tenet of MI is that motivation to change can best be elicited *from* the client rather than being imposed *upon* the client, and that direct persuasion is not effective in resolving ambivalence to change. This counseling style is generally a quiet and evocative one. Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction. Rather than a teacher-student relationship, client and facilitator join together in a working partnership (Dia, et al., 2009). In one RCT study, MI has been found to be effective with couples (Woodin & O'Leary, 2010). According to the most methodologically-sound studies, adding an MI component to a traditional psychoeducational batterer intervention curriculum correlates positively with a strong client-facilitator alliance, greater homework compliance, lower dropout rates, and reduced rates of physical and psychological abuse upon program completion (Alexander, et al., 2010; Musser, et al., 2008; Scott, et al., 2011; Taft, et al., 2003;

### **Implications for Group Treatment**

## Beyond Gender

The importance of a working therapeutic alliance is clear: mismatches between client and facilitator can lead to drop out, resistance, or phony compliance; and can occur due to personality factors or because of the program itself — for example, when a family-only client who wants to work on anger issues is directed instead to address gendered attitudes. Also relevant are ethnic and cultural differences. Culturally-focused psychotherapies have been found to be more effective than traditional evidence-based treatments by a factor of  $d = .32$  (Benish, Quintana, & Wampold, 2011). Clearly, a viable therapeutic alliance cannot be established when clients feel misunderstood due to their particular ethnic identity or sexual orientation.

At the same time, clients must also be helped in engaging with each other, in order to foster group cohesion. When clients are engaged, they are more motivated to acquire and practice actions that will help them become non-violent. Taking positive actions helps not only with a client's specific problems (e.g., aggression), but increases overall confidence and well-being which leads to more positive actions. This process occurs regardless of the intervention so long as that model appeals to the client, there is a reasonable concordance with the model's philosophy and its interventions, and the interventions provide tools with which to address a client's risk factors (Wampold & Imel, 2015). Thus, time-outs and active listening can be seen as ways to overcome a patriarchal mind-set (as exemplified in the Duluth model); or strengthening, practicing, and reinforcing positive behavior (as seen with the CBT model). What matters is that the individual is sufficiently motivated and stays long enough for the program to work.

**Research on group facilitation.** The effectiveness of the group format depends, to a large extent, on the qualities of the facilitator. The reader may recall the BIP outcome study cited earlier, finding an unstructured group less effective than a structured one with or without a peer as leader (Edleson & Syers, 1990). Even in self-help programs such as A.A., group meetings

## Beyond Gender

operate within a proscribed format with someone assigned to enforce group guidelines.

Fortunately, there is a large body of research on group facilitation, including qualitative investigations of BIPs that have identified some common client preferences.

In general, across all types of counseling groups, research has identified certain facilitator characteristics associated with positive group outcomes (Corey, et al., 2010; DeLucia-Waack, et al., 2014; Fuhrman & Burlingame, 1990; Morran, et al., 2004). They include courage; dedication and commitment; openness and non-defensiveness; goodwill; genuineness and caring; and the ability to identify with a client's pain. There is a growing body of qualitative literature where BIP facilitators and/or clients in small focus groups have been asked to talk about their experiences, including what aspects of their group experience may have helped motivate them to change their abusive behavior (Bolton et al., 2016; Boston, 2010; Chovanec, 2012; Morrison, et al., in press; Roy, et al., 2013; Roy, et al., 2014; Scott & Wolfe, 2000; Silvergleid & Mankowski, 2006). Throughout these studies, there is a consensus that clients are more engaged and motivated when facilitators are caring and committed; are non-judgmental; maintain a safe working group environment; are honest, humble and genuine; are willing to challenge client behaviors, but in non-confrontational and respectful ways; and who are knowledgeable about IPV and able to provide information and tools with which to change.

However, no matter how well-attuned a group facilitator might be to issues of culture or sexual orientation, some clients will never feel comfortable or safe enough to develop that motivation even not accepted or understood by the other group members. Gondolf (2007), for example, did not find a culturally-focused group of African-American IPV perpetrators as effective as a racially mixed CBT group, but he did report greater effectiveness for men who professed a stronger black identity. Some men may feel more comfortable sharing some of their

## Beyond Gender

concerns (e.g., related to sex) with other men, and feel judged or intimidated in a mixed-gender group. Results from the 2016 batterer intervention survey, previously discussed, suggests that many LGBTQ perpetrators might have more positive treatment outcomes when included in a group of their peers. The author has observed, over a period of nearly 30 years conducting BIPs in the San Francisco Bay Area, that lesbian clients are more readily accepted in traditional female groups than are gay men, or trans individuals, in traditional male-only groups. Interestingly, gay men who exhibit typically masculine characteristics are more easily integrated than those with more effeminate features, but even so, only in areas where tolerance of gays is highest, such as in San Francisco. Most gay men, therefore, and some lesbians, would benefit from individual work with a therapist versed in LGBTQ issues. When at all possible, client preferences should be taken into account when assigning them to any particular group.

BIPs may want to incorporate findings from these qualitative studies into their agency's facilitator guidelines. For a valid, empirically-based means by which to evaluate group functioning, readers are advised to familiarize themselves with the Group Engagement Measure (GEM) (Macgowan, 2006), which measures client engagement in terms of attendance, contribution, relating to facilitator, contracting (supporting group norms), working on own problems, and working on other group members' problems.

### **Conclusions and Recommendations**

What we know about IPV treatment has come almost exclusively from studies with male perpetrators, and there is essentially no empirical research on LGBTQ offenders. Risk factor research, and the few studies that have investigated IPV dynamics among same-sex couples, suggest that a common curriculum might adequately address the treatment needs of all offenders, especially if such a curriculum is delivered by a competent, engaged facilitator within the context

## Beyond Gender

of a supportive, working group environment. This should remain speculative, however, until methodologically-sound outcome studies are conducted with female and LGBTQ offenders.

Clearly, research scholars ought to further investigate the effects of facilitator personality and group leadership skills on client engagement and treatment outcomes. As suggested by Pollio (2006), there is a need for more “bottom-up” cooperation between practitioners and researchers rather than “top-down” where scholars initiate studies based on the concerns, observations, and experiences of front-line providers rather than continuously test and re-test existing theories of interest primarily to academics. Given the demonstrated effectiveness of individual and couples therapy, there is also a need for additional research on the best ways these modalities can be used, whether as the primary treatment approach or in conjunction with group. Meanwhile, findings in the areas of curriculum content, the relationship between therapist/group facilitator and client(s), and group facilitation skills arguably provide BIPs enough of an empirical basis upon which to build effective programs and achieve some basic version of evidence-based practice (see Table 3). Treatment providers need to know who their clients are and acknowledge when their program may not be suitable for a particular individual (e.g., trying to convince an egalitarian man that he is a misogynist or “patriarchal” may lead to unnecessary resistance and reduced engagement). They are also advised to network with other providers like, for example, the Association of Domestic Violence Intervention Programs.<sup>2</sup>

The author’s manualized treatment program, Alternative Behavior Choices (ABC), employs a curriculum that addresses the major IPV risk factors (Hamel, 2014), with a focus on teaching emotion management and relationship skills. Because the risk factors and motivations for violence are comparable across gender and sexual orientation, the same curriculum is used

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<sup>2</sup> Information about the Association of Domestic Violence, also known as ADVIP, can be found at [www.domesticviolenceintervention.net](http://www.domesticviolenceintervention.net)



## Beyond Gender

for male and female participants. Clients who are court-mandated to a psychoeducational group format and prevented from utilizing alternative treatment options, are nonetheless administered a variety of assessment instruments to measure their level of interpersonal functioning. The results of these questionnaires are then subsequently used to set treatment goals. This, along with the client-centered and an MI-oriented stance of its facilitators coupled with the ample time allotted for open discussion, helps clients to benefit from a shared group experience while being acknowledged as unique individuals; each with his/her own particular treatment needs.

### **Making Gender Relevant Again**

The preference among policy makers and intervention providers for gender-based treatment has hindered the common effort to reduce rates of IPV in our communities. Aside from the cognitive biases discussed previously, or the inherent self-perpetuating nature of institutions and reluctance by those with power to relinquish that power, the persistence of what Dutton (2010) calls the “gender paradigm” has several other explanations. Although patriarchal structures throughout the world give men significant social, economic, and political advantages, women have traditionally viewed the home as their domain where they may feel empowered to use violence to maintain their status (Straus, 1999). Yet, as the meta-analytic review by Archer (2004) reminds us, men perpetrate the much larger share of both verbal and physical aggression outside the home, including violent crimes — a reality that is obvious to everyone. Some have argued that some resistance to gender-inclusive intervention models may stem from a sense of collective guilt over the poor treatment of women throughout history, and a misguided effort to “balance the scales” (Corvo & Johnson, 2012).

Minimizing the impact of female-perpetrated IPV and pretending that patriarchy is the sole (or principal) cause of violence by men does little to advance treatment effectiveness or

## Beyond Gender

keep victims safe. The near-obsessive focus in the field of IPV on identifying and eradicating hostile forms of sexism is misguided, and ironically manifests as a sort of “benevolent sexism” (Glick & Fiske, 2001) that regards women as uniformly helpless and like children: lacking the agency to make responsible decisions. Those who wish to advance the rights of women should engage in social and political action that will achieve this goal and vote accordingly. Those who wish to lower rates of IPV (against women or men, gay or straight), should favor interventions found to be effective. Both are noble pursuits; neither of them benefits from incompetence and ignorance. Ultimately, it does not serve women well when they are uniformly assumed to be victims, and when ideology is allowed to trump science.

The research presented in this chapter provides a framework in which gender can be considered from an empirical rather than political stance. Early in the ABC curriculum, research is cited showing that in most respects, there are far more similarities between men and women than there are differences (Hyde, 2014). The principles of egalitarian relationships are discussed, both as an intrinsic good and because couples who are in agreement about gender roles are less likely to dominate one another or engage in the type of conflict that can lead to violence. Sex-based stereotypes are challenged, and participants are asked to ponder the consequences of maintaining either male privilege or, alternatively, female privilege (see Table 4). Clients are asked to complete monthly CBT logs, in which they are expected to identify and challenge all forms of sexist attitudes based in misogyny as well as misandry (e.g., women regarded as “sex objects,” men regarded as “success objects”). Rather than reinforce stereotypes — which gender-based models do when they assume, for example, that all men seek power over women — these attitudes are included within the broader category of irrational beliefs.

## Beyond Gender

Men and women of course differ in important ways. IPV dynamics are not unaffected by a person's sex or gender roles. For example, women — who are more physically impacted by IPV — have correspondingly greater fear of their partner and the inherently more threatening nature of men's aggression is often checked by male norms of chivalry. Within the context of acquiring effective impulse control and relationship-building skills, BIP clients need to be aware of additional differences in the way men and women manage emotions and engage in interpersonal communication. Ignorance of those differences can lead to the toxic kinds of gender stereotypes mentioned above and unnecessarily create relationship discord. For example, while emotions are experienced at comparable rates across gender, women more readily remember emotion-laden situations which men may view as evidence of malicious resentment or pickiness. In fact, women do experience anger for longer periods, but also are more likely than men to feel ashamed about it. Because they are more likely to report intense emotions, and due to higher levels of emotion recognition and empathy, women can be dismissed as “more emotional” or “irrational,” thus making them feel unimportant.

Additionally, compared to men, women are better at decoding non-verbal expressions of emotion, and using emotions to understand situations and facilitate solutions to conflicts. This is a great quality but may be threatening to some men who view it as an attempt to dominate and control them. On the other hand, the difficulty that many men have in expressing emotions, especially those that make them feel vulnerable (e.g., hurt, helplessness), may be interpreted as “not caring.” Similar gender-based misunderstandings have been pointed out by Tannen (1990) — for example, how men tend to value autonomy and being competent more than emotional connection and intimacy, whereas women place a higher value on connection and intimacy; or how men typically engage in *report talk* (to exchange information), whereas women engage in

## Beyond Gender

*rappport talk* (to make a connection). Needless to say, while these are traditional patterns are quite common, gender roles vary widely, and particularly with respect to sexual orientation.

Participants are reminded that exceptions are numerous and varied (the woman who loves to solve problems, the man who insists on talking things out, the “femme” lesbian who makes the major decisions in her relationship). The objective is to challenge stereotypes, not reinforce them. It is the author’s experience that allowing free discussion of gender roles and socialization, within an empirically-sound educational context, helps clients to better recognize their partners’ positive intentions and more clearly delineate their role and responsibilities in the decision-making process. Clients are empowered when they are given options. Like any other skill, emotion management and communication can be learned. The man, for example, who is taught that a reluctance to exhibit emotions is not evidence of pathology but rather a reality that both partners need to take into account, may become sufficiently motivated to address this issue, thereby leading to greater acceptance from his partner, and enhanced relationship satisfaction.

References

- Alexander, P. C., Morris, E., Tracy, A., & Frye, A. (2010). Stages of change and the group treatment of batterers: A randomized clinical trial. *Violence and Victims, 25*, 571-587. doi: 10.1891/0886-6708.25.5.571
- American Psychological Association Presidential Task Force on Evidence-Based Practice (2006). Evidence based practice in psychology. *American Psychologist, 61*(4), 271-285. doi: 10.1037/0003-066X.61.4.271
- Archer, J. (2004). Sex differences in aggression in real-world settings: A meta-analytic review. *Review of General Psychology, 8*(4), 291-322. doi: 10.1037/1089-2680.8.4.291
- Babcock, J. C., Canady, B. E., Graham, K., & Schart, L. (2007). The evolution of battering interventions: From the Dark Ages into the Scientific Age. In J. Hamel & T. L. Nicholls (Eds). *Family interventions in domestic violence: A handbook of gender-inclusive theory and treatment*. (pp. 215-244). NY: Springer.
- Babcock, J., Green, C., & Robie, C. (2004). Does batterers' treatment work: A meta-analytic review of domestic violence treatment. *Clinical Psychology Review, 23*, 1023-1053. doi: 10.1016/j.cpr.2002.07.001
- Babcock, J., Armenti, N., Cannon, C., Lauve-Moon, K., Buttell, F., Ferreira, R., ... Solano, I. (2016). Domestic violence perpetrator programs: A proposal for evidence-based standards in the United States. *Partner Abuse, 7*(4), 1-107. doi: 10.1891/1946-6560.7.4.355
- Babcock, J., Miller, S., & Siard, C. (2003). Toward a typology of abusive women: Differences between partner-only and generally violent women in the use of violence. *Psychology of Women Quarterly, 27*(2), 153-161. doi: 10.1111/1471-6402.00095

## Beyond Gender

- Bartholomew, K., Regan, K., Oram, D. & White, M. (2008). Correlates of partner abuse in male same-sex relationships. *Violence and Victims*, 23 (3), 344-360.
- Bates, E. A., Graham-Kevan, N., & Archer, J. (2014). Testing predictions from the male control theory of men's partner violence. *Aggressive Behavior*, 40(1) 42-55.  
doi: 10.1002/ab.21499
- Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally-adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology*, 58(3), 279-289. doi: 10.1037/a0023626
- Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., Chen, J., & Stevens, M. R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from: [http://www.cdc.gov/ViolencePrevention/pdf/NISVS\\_Executive\\_Summary-a.pdf](http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Executive_Summary-a.pdf)
- Bolton, K., Lehmann, P., Jordan, C., & Frank, L. (2016). Self-determined goals in a solution-focused batterer intervention program: Application for building client strengths and solutions. *Journal of Human Behavior on the Social Environment*, 26, 541-548.  
doi: 10.1080/10911359.2016.1172996
- Bonta, J. (1996). Risk-needs assessment and treatment. In A. T. Harland (Ed.), *Choosing correctional options that work: Defining the demand and evaluating the supply* (pp. 18–32). Thousand Oaks, CA: Sage.
- Boston, D. (2010). *Gendered perceptions of batterer intervention co-facilitation*. Dissertation.
- Bowen, E. (2009). *Domestic violence treatment for abusive women: A treatment manual*. New York: Routledge.

## Beyond Gender

- Brown, M., & Groscup, J. (2009). Perceptions of same-sex domestic violence among crisis center staff. *Journal of Family Violence, 24*, 87-93.
- California State Auditor (2006). Batterer intervention programs: County probation departments could improve their compliance with state law, but progress in batterer accountability also depends on the courts. Retrieved from <http://www.bsa.ca.gov/pdfs/sr2008/2005-130.pdf>.
- Cannon, C., Hamel, J., Buttell, F. P., & Ferreira, R. J. (2016). A survey of domestic violence perpetrator programs in the U.S. and Canada: Findings and implications for policy intervention. *Partner Abuse, 7*(3), 226-276. doi: 10.1891/1946-6560.7.3.226
- Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse, 3*(2), 231-280.  
doi: 10.1891/1946-6560.3.2.231
- Carrillo, R., & Zarza, M. J. (2006). *El hombre noble buscando balance: An intervention model for Latino perpetrators of intimate partner violence*. Unpublished manuscript.
- Chovanec, M. (2012). Examining engagement of men in a domestic abuse program from three perspectives: An exploratory multimethod study. *Social Work with Groups, 35*, 362-378.  
doi: 10.1080/01609513.2012.669351
- Coleman, V. (2002). Treating the lesbian batterer: Theoretical and clinical considerations – A contemporary psychoanalytic perspective. In: D. Dutton & D. Sonkin (Eds.), *Intimate violence: Contemporary treatment innovations* (pp. 159-206). New York, NY: Haworth Maltreatment & Trauma Press.
- Corey, M., Corey, G., & Corey, C. (2010). *Groups: Process and practice* (8<sup>th</sup> ed.). Belmont, CA: Brooks/Cole.

## Beyond Gender

- Corvo, K., Dutton, D., & Chen, W. (2009). Do Duluth model interventions with perpetrators of domestic violence violate mental health professional ethics? *Ethics & Behavior, 19*, 323-340. doi: 10.1080/10508420903035323
- Corvo, K., & Johnson, P. J. (2003). Vilification of the “batterer”: How blame shapes domestic violence policy and interventions. *Aggression and Violent Behavior, 8*, 259-281. doi: 10.1016/S1359-1789(01)00060-X
- Corvo, K. and Johnson, P. J. (2012). An eye for an eye: Gender revanchisme and the negation of attachment in domestic violence policy. *Partner Abuse, 3*(1), 89-106. doi: 10.1891/1946-6560.3.1.89
- Coulter, M., & VandeWeerd, C. (2009). Reducing domestic violence and other criminal recidivism: Effectiveness of a multilevel batterers intervention program. *Violence and Victims, 24*(2), 139-152. doi: 10.1891/0886-6708.24.2.139
- Daly, J. E., & Pelowski, S. (2000). Predictors of dropout among men who batter: A review of studies with implications for research and practice. *Violence and Victims, 15*(2), 137-10. doi: 10.1891/0886-6708.15.2.137
- DeLucia-Waack, J., Kalodner, C., & Riva, M. (2014). *Handbook of group counseling and psychotherapy, 2<sup>nd</sup> edition*. Thousand Oaks, CA: Sage.
- Dia, D., Simmons, C., Oliver, M., & Cooper, L. (2009). Motivational interviewing for perpetrators of intimate partner violence. In P. Lehmann & C. Simmons (Eds.), *Strengths-based batterer intervention: A new paradigm in ending family violence* (pp. 87-112). New York: Springer.
- Dobash, R. P., & Dobash, R. E. (1979). *Violence against wives: A case against the patriarchy*. New York: The Free Press.



## Beyond Gender

- Dunford, F. W. (2000). The San Diego Navy experiment: An assessment of interventions for men who assault their wives. *Journal of Consulting and Clinical Psychology, 68*, 468-476. doi: 10.1037/0022-006X.68.3.468
- Dutton, D. G. (2010). The gender paradigm and the architecture of anti-science. *Partner Abuse, 1*(1), 5-25. doi: 10.1891/1946-6560.1.1.5
- Dutton, D. G., & Corvo, K. (2006) Transforming a flawed policy: A call to revive psychology and science in domestic violence research and practice. *Aggression and Violent Behavior, 11*, 457-483. doi: 10.1016/j.avb.2006.01.007
- Eckhardt, C. I., Holtzworth-Munroe, A., Norlander, B., Sibley, A., & Cahill, M. (2008). Readiness to change, partner violence subtypes, and treatment outcomes among men in treatment for partner assault. *Violence and Victims, 23*, 446-475. doi: 10.1891/0886-6708.23.4.446
- Eckhardt, C. I., Murphy, C., Black, D., & Suhr, L. (2006; July-August). Intervention programs for perpetrators of intimate partner violence: Conclusions from a clinical research perspective. *Public Health Reports (Washington, D.C.: 1974), 121*, 369-381. doi: 10.1177/003335490612100405
- Eckhardt, C. I., Murphy, C. M., Whitaker, D. J., Sprunger, J., Dykstra, R., & Woodard, K. (2013). The effectiveness of intervention programs for perpetrators and victims of intimate partner violence. *Partner Abuse, 4*(2), 196-231. doi: 10.1891/1946-6560.4.2.196
- Edleson, J. L., & Syers, M. (1990). Relative effectiveness of group treatments for men who batter. *Social Work Research and Abstracts, 26*(2), 10-18. doi: 10.1093/swra/26.2.10
- Esquivel-Santovena, E. E., Lambert, T., & Hamel, J. (2013). Partner abuse worldwide. *Partner Abuse, 4*(1), 6-75. doi: 10.1891/1946-6560.4.1.e14

## Beyond Gender

- Felson, R. (2002). *Violence and gender re-examined*. Washington, DC: American Psychological Association.
- Fruzzetti, A. E., & Levensky, E. R. (2000). Dialectical behavior therapy for domestic violence: Rationale and procedures. *Cognitive and Behavioral Practice, 7*, 435-447.  
doi: 10.1016/S1077-7229(00)80055-3
- Fuhriman, A., & Burlingame, G. M. (1990). Consistency of matter: A comparative analysis of individuals and group process variables. *The Counseling Psychologist, 18*(1), 6-63.  
doi: 10.1177/0011000090181002
- Glick, P., & Fiske, S. T. (2001). An ambivalent alliance: Hostile and benevolent sexism as complementary justifications for gender inequality. *American Psychologist, 56*(2), 109-118. doi: 10.1037/0003-066X.56.2.109
- Gondolf, E. W. (2007). Culturally-focused batterer counseling for African-American men: A clinical trial of re-assault and re-arrest outcomes. *Criminology and Public Policy, 6*, 341-366. doi: 10.1111/j.1745-9133.2007.00441.x
- Gondolf, E. W. (2011). The weak evidence for batterer program alternatives. *Aggression and Violent Behavior, 16*, 347-353. doi: 10.1016/j.avb.2011.04.011
- Gondolf, E. W. (2012). *The future of batterer programs: Reassessing evidence-based practice*. Lebanon, NH: Northeastern University Press.
- Gover, A. R. (2011). New directions for domestic violence offender treatment standards: Colorado's innovative approach to differentiated treatment. *Partner Abuse, 2*(1), 95-120.  
doi: 10.1891/1946-6560.2.1.95
- Hamel, J. (2011). In dubious battle: The politics of mandatory arrest and dominant aggressor laws. *Partner Abuse, 2*(2), 224-245. doi: 10.1891/1946-6560.2.2.224

## Beyond Gender

- Hamel, J. (2014). *Gender-inclusive treatment of intimate partner abuse: Evidence-based approaches*. (2<sup>nd</sup> ed.). New York: Springer.
- Hamel, J., Langhinrichsen-Rohling, J., & Hines, D. A. (2012). More than a literature review: The partner abuse state of knowledge articles and online database. *Partner Abuse, 3*(2), 131-139. doi: 10.1891/1946-6560.3.2.131
- Hirschel, D. (2008). Domestic violence cases: What research shows about arrest and dual arrest cases. Retrieved from <http://www.ojp.usdoj.gov/nij/publications/dv-dual-arrest-222679/dv-dual-arrest.pdf>
- Holtzworth-Munroe, A., & Stewart, G. L. (1994). Typologies of male batterers: Three subtypes and the differences among them. *Psychological Bulletin, 116*, 476-497.  
doi: 10.1037/0033-2909.116.3.476
- Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9-16. doi: 10.1037/a0022186
- Hyde, J. S. (2014). Gender similarities and differences. *Annual Review of Psychology, 65*, 373-398. doi: 10.1146/annurev-psych-010213-115057
- Jacobsen, C. A. (2013). *Social workers reflect on engagement with involuntary clients*. (Unpublished master's thesis). St. Catherine's University, St. Paul, Minnesota
- Jasinski, J., Blumenstein, L., & Morgan, R. (2014). Testing Johnson's typology: Is there gender symmetry in intimate terrorism? *Violence and Victims, 29*(1), 73-88.  
doi: 10.1891/0886-6708.VV-D-12-00146
- Johnson, M. P. (2008). *A typology of domestic violence: Intimate terrorism, violence resistance, and situational couple violence*. Lebanon, NH: Northeastern University Press.
- Knack, W. A. (2009). *Psychotherapy and Alcoholics Anonymous: An integrated approach*.

- Journal of Psychotherapy Integration*, 19(1), 86-109. doi: 10.1037/a0015447
- Langhinrichsen-Rohling, J., Misra, T. A., Selwyn, C., & Rohling, M. L. (2012). Rates of bi-directional versus unidirectional intimate partner violence across samples, sexual orientations, and race/ethnicities: A comprehensive review. *Partner Abuse*, 3(2), 199-230. doi: 10.1891/1946-6560.3.2.199
- Lee, M., Uken, A., & Sebold, J. (2009). Accountability for change: Solution-focused treatment of domestic violence offenders. In P. Lehmann & C. Simmons (Eds.), *Strengths-based batterer intervention: A new paradigm in ending family violence* (pp. 55-86). New York: Springer.
- Letellier, P. (1994). Gay and bisexual male domestic violence victimization. *Violence and Victims*, 9(2), pp. 95-106.
- Macgowan, M. J. (2006). The Group Engagement Measure: A review of its conceptual and empirical properties. *Journal of Groups in Addiction & Recovery*, 1(2), 33-52. doi: 10.1300/J384v01n02\_04
- MacLeod, D., Pi, R., Smith, D., & Rose-Goodwin, L. (2008). Batterer intervention systems in California: An evaluation. Retrieved from <http://www.courtinfo.ca.gov/reference/documents/batterer-finalreport.pdf>
- Maiuro, R., & Eberle, J. (2008). State standards for domestic violence perpetrator treatment: Current status, trends, and recommendations. *Violence and Victims*, 23(2), 133-155. doi: 10.1891/0886-6708.23.2.133
- Malley-Morrison, K., & Hines, D. (2004). Family violence in a cultural perspective: Defining, understanding, and combating abuse. Thousand Oaks, CA.: Sage.
- Maruna, S. (2001). *Making good: How ex-convicts reform and rebuild their lives*. Washington,

## Beyond Gender

D.C.: American Psychological Association.

Maxwell, C. D., Garner, J. H., & Fagan, J. A. (2001, July). *The effects of arrest on intimate partner violence: New evidence from the spouse assault replication program*. National Institute of Justice, NCJ 188199. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/188199.pdf>

McGrady, B. S. (1994). Alcoholics Anonymous and behavior therapy: Can habits be treated as diseases? Can diseases be treated as habits? *Journal of Consulting and Clinical Psychology, 62*, 1159-1166. doi: 10.1037/0022-006X.62.6.1159

McKenry, P., Serovich, J., Mason, T., & Mosack, K. (2006). *Journal of Family Violence, 21*, 233-243.

Miller, M., Drake, E., & Natziger, M. (2013). What works to reduce recidivism by domestic violence offenders? (Document No. 13-01-1201). Olympia: Washington State Institute for Public Policy.

Miller, S., (2010). Discussing the Duluth curriculum: Crating a process of change for men who batter. *Violence against Women, 16*, 1007-1021.  
doi: 10.1177/1077801210379318

Morran, D. K., Stockton, R., & Whittingham, M. H. (2004). Effective leader interventions for counseling and psychotherapy groups. In J. L. DeLucia-Waack, D. A. Gerrity, C. R. Kalodner, & M. T. Riva (Eds.), *Handbook of group counseling and psychotherapy* (pp. 91-103). Thousand Oaks: Sage. doi: 10.4135/9781452229683.n7

Morrison, P. K., Cluss, P., Hawker, L., Miller, E., George, D., Bicehouse, T., Fleming, R., & Chang, J. (2019). Male IPV perpetrators' perspectives on facilitation of batterer intervention programs: Results from a 2-year study. *Partner Abuse*.

## Beyond Gender

- Murphy, C. M., & Eckhardt, C. I. (2005). *Treating the abusive partner: An individualized cognitive-behavioral approach*. New York: The Guilford Press.
- Musser, P. H., Semiatin, J. N., Taft, C. T., & Murphy, C. M. (2008). Motivational interviewing as a pregroup intervention for partner-violent men. *Violence and Victims, 23*, 539-557. doi: 10.1891/0886-6708.23.5.539
- Nicholls, T., Desmarais, S., Douglas, K., & Kropp, R. (2007). Violence risk assessments with perpetrators of intimate partner abuse. In: J. Hamel & T. Nicholls (Eds.), *Family Interventions in Domestic violence: A Handbook of Gender-Inclusive Theory and Treatment* (pp. 275-302). New York: Springer.
- Pence, E. (1999). Some thoughts on philosophy. In M. F. Shepherd & E. L. Pence (Eds.), *Coordinating community responses to domestic violence: Lessons from Duluth and beyond* (pp. 29–30). Thousand Oaks, CA: Sage.
- Pence, E. & Paymar, M. (1993). *Education groups for men who batter: The Duluth model*. New York: Springer.
- Pollio, D. E. (2006). The art of evidence-based practice. *Research on Social Work Practice, 16* (2), 224-232. doi: 10.1177/1049731505282981
- Potter-Efron, R. T. (2005). *Handbook of anger management: Individual, couple, family and groups approaches*. New York: The Haworth Press.
- Prochaska, J. O., DiClemente, C., & Norcross, J. C. (1992). In search of how people change: Applications to the addictive behaviors. *American Psychologist, 47*, 1102-1114. doi: 10.3109/10884609309149692
- Richards, T. N., Gover, A. R., & Tomsich, E. A. (2015). *Colorado's innovative response to domestic violence offender treatment: Current achievements and recommendations for*

- the future*. Denver, CO: Buechner Institute for Governance, School of Public Affairs, University of Colorado Denver.
- Richards, T. N., Gover, A., Tomsich, E.A., Hansen, J., & Davis, C. R. (2017). The implementation of state-mandated standards for batterer intervention programs: The Colorado experience. *Violence and Victims*, 32(2), 279-298.  
doi: 10.1891/0886-6708.VV-D-15-00091
- Roy, V., Chateauvert, J., & Richard, M.C. (2013). An ecological examination of factors influencing men's engagement in intimate partner violence groups. *Journal of Interpersonal Violence*, 28, 1798-1816. doi: 10.1177/0886260512469110
- Roy, V., Chateauvert, J., Drouin, M.E., & Richard, M.C. (2014). Building men's engagement in intimate partner violence groups. *Partner Abuse*, 5, 420-438.  
doi: 10.1891/1946-6560.5.4.42
- Saunders, D. G., & Hanusa, D. (1986). Cognitive-behavioral treatment of men who batter: The short-term effects of group therapy. *Journal of Family Violence*, 1(4), 357-372.  
doi: 10.1007/BF00978278
- Scott, K. L., & Wolfe, D. A. (2000). Change among batterers: Examining men's success stories. *Journal of Interpersonal Violence*, 15, 827-842. doi: 10.1177/088626000015008003
- Scott, K., King, C., McGinn, H. & Hosseini, N. (2011). Effects of motivational enhancement on immediate outcomes of batterer intervention. *Journal of Family Violence*, 26(2), 139-149. doi: 10.1007/s10896-010-9353-1
- Shlonsky, A., & Gibbs, L. (2004). Will the real evidence-based practice please stand up? Teaching the process of evidence-based practice to the helping professions. *Brief Treatment and Crisis Intervention*, 4(2), 137-153. doi: 10.1093/brief-treatment/mhh011

## Beyond Gender

- Silvergleid, C. S., & Mankowski, E. S. (2006). How batterer intervention programs work: Participant and facilitator accounts of process of change. *Journal of Interpersonal Violence, 21*(1), 139-159. doi: 10.1177/0886260505282103
- Sinclair, H. (2015). *Manalive V.I & P. Training Institute 1<sup>st</sup> Stage Class Manual*. Unpublished manual. Manalive, San Francisco, CA.
- Sonkin, D. J., & Durphy, M. (1997). *Learning to live without violence: A handbook for men*. Volcano, CA: Volcano Press.
- Stewart, L. A., Flight, J., & Slavin-Stewart, C. (2013). Applying effective corrections principles (RNR) to partner abuse interventions. *Partner Abuse, 4*, 494-534. doi: 10.1891/1946-6560.4.4.494
- Stosny, S. (1995). *Treating attachment abuse: A compassionate approach*. New York: Springer.
- Stosny, S. (2004). *Manual of the core value workshop*. North Charleston, NC: Book Surge Publishing.
- Straus, M. A. (1999). The controversy over domestic violence by women: A methodological, theoretical, and sociology of science analysis.” In X. B. Arriaga & S. Oskamp (Eds.), *Violence in Intimate Relationships* (pp. 17-44). Thousand Oaks, CA: Sage.
- Stuart, R. B. (2005). Treatment for partner abuse: Time for a paradigm shift. *Professional Psychology: Research and Practice, 36*, 254-263. doi: 10.1037/0735-7028.36.3.254
- Sugarman, D. B. & Frankel, S. L. (1996). Patriarchal ideology and wife-assault: A meta-analytic review. *Journal of Family Violence, 11*(1), 13-40. doi: 10.1007/BF02333338



## Beyond Gender

- Swift, J. K., Greenberg, R. P., Whipple, J. L., & Kominiak, N. (2012). Practice recommendations for reducing premature termination in therapy. *Professional Psychology: Research and Practice, 43*, 379-387. doi: 10.1037/a0028291
- Taft, C. T., Murphy, C. M., King, D. W., Musser, P. H., & DeDyn, J. M. (2003). Process and treatment adherence factors in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology, 71*, 812-820.  
doi: 10.1037/0022-006X.71.4.812
- Taft, C. T., Creech, S. K., Gallagher, M. W., Macdonald, A., Murphy, C. M., & Monson, C. M. (2016). Strength at Home Couples Program to prevent military partner violence: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 84*, 935-945.  
doi: 10.1037/ccp0000129
- Tannen, D. (1990). *You just don't understand*. New York, NY: Ballantine.
- Ting, L., Jordan-Green, L., Murphy, C. M., & Pitts, S. C. (2009). Substance use problems, treatment engagement, and outcomes in partner violence men. *Research on Social Work Practice, 19*, 395-406. doi: 10.1177/1049731508329418
- Tracey, T. J. G., Wampold, B. E., Goodyear, R. K., & Lichtenberg, J. W. (2015). Improving expertise in psychotherapy. *Psychotherapy Bulletin, 50*(1), 7-13.
- Vollmer, S., Spada, H., Caspar, F., & Burri, S. (2013). Expertise in clinical psychology. The effects of university training and practical experience on expertise in clinical psychology. *Frontiers in Psychology, 4*, 1-12. doi: 10.3389/fpsyg.2013.00141
- Walters, M., Chen, J., & Breiding, M. (2013, January). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Findings on victimization by sexual orientation. Atlanta, Georgia: National Center for Injury Prevention and Control, Centers for Disease

## Beyond Gender

Control and Prevention.

Welland, C. G., & Ribner, N. (2008). *Healing from violence: Latino men's journey to a new masculinity*. New York: Springer.

Welland, C. G. (2011). Individual treatment for a Latino partner abusive man: A case study. *Partner Abuse, 2*, 468-483. doi: 10.1891/1946-6560.2.4.468

West, C. (1998). Leaving a second closet: Outing partner violence in same-sex couples. In: J. Jasinski & L Williams (Eds.). *Partner Violence: A comprehensive review of 20 years of research*. Thousand Oaks, CA: Sage.

West, C. (2012). Partner abuse in ethnic minority and gay, lesbian bisexual, and transgender populations. *Partner Abuse, 3*(3), 336-357.

Wexler, D. B. (2000). *Domestic violence 2000: An integrated skills program for men, group leader's manual*. New York: Norton.

Wiechelt, S. A. (2015). Alcoholics Anonymous: Warts and all. *Substance Use & Misuse, 50*, 1011-1014. doi: 10.3109/10826084.2015.1010997

Woodin, E. M., & O'Leary, K. D. (2010). A brief motivational intervention for physically aggressive dating couples. *Prevention Science, 11*, 371-383.  
doi: 10.1007/s11121-010-0176-3

Zarling, A., Lawrence, J., & Marchman, J. (2015). A randomized controlled trial of acceptance and commitment therapy for aggressive behavior. *Journal of Consulting and Clinical Psychology, 83*(1), 199-212. doi: 10.1037/a0037946

Zarling, A., Bannon, S., & Berta, M. (2017). Evaluation of acceptance and commitment therapy for domestic violence offenders. *Psychology of Violence, 9*(3), 257-266.

## Beyond Gender

Table 1. *Symmetry and asymmetry across gender*

Symmetry	Asymmetry	Mixed/Inconclusive
Rates of physical abuse	Rates of sexual abuse	Impact of emotional abuse
Rates of emotional abuse	Rates of physical stalking	Abuse in non- Western countries
Rates of non-physical stalking	Impact of physical abuse	
Causes and risk factors		
Impact on children/families		
Self-reported motives		

Table 2. Therapeutic factors

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%

Table 3. “Big Three” areas of batterer intervention group treatment

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

Table 4. Questions on gender roles and gender privilege.

Men

Do you see yourself as the “man of the house?” Do you refuse to do household tasks because it’s “women’s work?” Do you expect sex or having your dinner prepared because this is your “right” as a man? Do you expect your partner to always be loving and understanding, because “that’s how women should be?” Do you dismiss what she says because she’s too “emotional”?

Women

Do you think of the home as your “domain,” or that being a woman or mother gives you certain privileges? When you ask your husband to help with household tasks, do you supervise him, or re-do these tasks yourself so they are done “right?” Do you put pressure on him to work more, because “men are supposed to provide?” Do you justify hitting him because he’s physically bigger and should just “take it”? If divorcing, would you automatically assume you should get custody because women are automatically the superior parents?