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Domestic Violence Perpetrator Programs: A Proposal for Evidence-Based Standards in the United States

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In the United States, the judicial system response to violence between intimate partners, or intimate partner violence (IPV), typically mandates that adjudicated perpetrators complete a batterer intervention program (BIP). The social science data has found that these programs, on the whole, are only minimally effective in reducing rates of IPV. The authors examined the social science literature on the characteristics and efficacy of BIPs. More than 400 studies were considered, including a sweeping, recently conducted survey of BIP directors across the United States and Canada. Results of this review indicate that the limitations of BIPs are due, in large part, to the limitations of current state standards regulating these programs and, furthermore, that these standards are not grounded in the body of empirical research evidence or best practices. The authors, all of whom have considerable expertise in the area of domestic violence perpetrator treatment, conducted an exhaustive investigation of the following key intervention areas: overall effectiveness of BIPs; length of treatment/length of group sessions; number of group participants and number of facilitators; group format and curriculum; assessment protocol and instruments; victim contact; modality of treatment; differential treatment; working with female perpetrators; working with perpetrators in racial and ethnic minority groups; working with lesbian, gay, bisexual, and transgender (LGBT) perpetrators; perpetrator treatment and practitioner–client relationships; and required practitioner education and training. Recommendations for evidence-based national BIP standards were made based on findings from this review.

Keywords: batterer intervention; intimate partner violence (IPV); domestic violence; perpetrator treatment; batterer intervention program (BIP) standards

Domestic violence, otherwise known as intimate partner violence (IPV), partner violence, or partner abuse (PA), is an important public health issue (Carbone-López, Kruttschnitt, & Macmillan, 2006; Hines, Malley-Morrison, & Dutton, 2013; Krug, Mercy, Dahlberg, & Zwi, 2002; Saltzman, Green, Marks, & Thacker, 2000). Recently, a comprehensive literature review found that approximately 1 in 4 women and 1 in 5 men are physically victimized by a romantic partner in their lifetime (Desmarais, Reeves, Nicholls, Telford, & Fiebert, 2012a, 2012b). Drawing on a sample of 4,741,000 women and 5,365,000 men, the National Intimate Partner and Sexual Violence Survey (NISVS) conducted by the Centers for Disease Control and Prevention (CDC; Black et al., 2011) reported 12-month incidence rates of 4.3 million minor (e.g., slapping, pushing) and 3.2 million severe (e.g., punching, beating up) female victimization and 5.1 million minor and 2.2 million severe male victimization. Most partner aggressive relationships involve mutual/bidirectional aggression (Langhinrichsen-Rohling, Misra, Selwyn, & Rohling, 2012; Straus & Gelles, 1990).

In their sweeping review of the literature, Partner Abuse State of Knowledge (PASK) authors Carney and Barner (2012) reported on 204 studies that provided perpetration rates on emotional abuse, stalking, and sexual coercion. Of these, the most prevalent were found to be various forms of emotional abuse, perpetrated by approximately 80% of respondents across samples. A higher percentage of women compared to men (40% vs. 32%) reported to having perpetrated *expressive abuse* (e.g., ridiculing, shaming, making derogatory comments), whereas rates of *coercive abuse* (e.g., threatening to harm, monitoring, isolating) were fairly equal across gender (41% female-perpetrated, 43% male-perpetrated). NISVS (Black et al., 2011) reported higher rates of expressive abuse victimization of women (12.3 million) compared to men (10.6 million). Men, however, were more likely to be victims of coercive abuse in comparison to women (17.3 million vs. 12.7 million).

Occurring far less frequently than coercive or expressive emotional abuse, stalking behaviors and sexual coercion have a more deleterious impact on victims. According to Carney and Barner (2012), 4.1%–8% of women and 0.5%–2% of men have been physically stalked once or more during their lifetime, of which 33%–50% was perpetrated by a romantic partner. When nonphysical forms of stalking were considered (e.g., repeated texting, calling the partner at work), gender differences were less pronounced. With respect to sexual coercion, national surveys have found a far greater proportion of women than men to have been sexually coerced at some point in their lifetime (4.5% vs. 0.2%). Among dating samples, gender differences not as great for sexual coercion when defined more broadly to include various forms of psychological coercion, such as intimating that the victim must be a homosexual if he does not agree to have sex, or taking advantage of one's partner while they are intoxicated.

Examinations of the context regarding physically violent episodes indicate that stress, jealousy, anger, retaliation for emotional hurt, and a desire to coerce or control one's partner are common motivations for both male and female perpetrators (Flynn & Graham, 2010; Langhinrichsen-Rohling, McCullars, & Misra, 2012). Risk factors include young age (younger than 30 years); stress from low income and unemployment; having

an aggressive personality, desire to dominate, poor impulse control, male hostility toward women and attitudes that support violence by either men and women; depression, emotional insecurity; alcohol and drug abuse; having witnessed violence between one's parents as a child, or having been abused or neglected by them; negative peer involvement; and being in an unhappy or high-conflict relationship. Except for a higher correlation for depression and alcohol use by women in comparison to men, risk factors for IPV are very comparable across gender (Capaldi, Knoble, Shortt, & Kim, 2012).

There are many serious consequences of IPV for adult victims, for children who witness parental IPV, and for society as a whole. Consequences of victimization for partners include health problems such as chronic pain, gastrointestinal problems, and gynecological problems (Lawrence, Orengo-Aguayo, Langer, & Brock, 2012; Lown & Vega, 2001) as well as physical injuries such as cuts and bruises, broken bones, and concussions (Lawrence et al., 2012; Sutherland, Bybee, & Sullivan, 2002). Psychological sequelae are also commonly experienced by victims and can include depression, anxiety, stress, posttraumatic stress, substance abuse, and suicidality (Dillon, Hussain, Loxton, & Rahman 2013; Golding, 1999; Lawrence et al., 2012; World Health Organization, 2013). Children and adolescents who witness partner violence are at increased risk for problems related to anxiety, depression, and aggression (MacDonell, 2012). Societal costs of IPV include an economic impact because of physical and psychological health care needs for victims and their children (Bonomi, Anderson, Rivara, & Thompson, 2009; Rivara et al., 2007) as well as absenteeism, tardiness, and decreased productivity and job satisfaction for victims in the workplace (Reeves & O'Leary-Kelly, 2007).

POLICIES ON INTIMATE PARTNER VIOLENCE INTERVENTION

Beginning in the 1980s, at the behest of advocates for battered women and other concerned citizens, legislatures across the United States began to enact tougher laws that would define domestic assaults, including spousal rape, as crimes and hold perpetrators legally accountable for their actions. In 1994, President Clinton signed into law the Violence Against Women Act (VAWA). VAWA dramatically increased the role of the federal government in the effort to stop domestic violence against women by providing funding and guidance to state and local governments for implementation of more vigorous law enforcement responses; improve coordination among and provide education to police, prosecutors, and judges; and provide funding for shelters and other services dedicated to helping battered women. There is now in place a network of organizations, private and public, on the national, state, and local levels, dedicated to making families safer, including about 2,000 shelters throughout the United States. A review of 135 studies finds that, on average, in the United States, approximately one-third of reported domestic violence offense and about three-fifths of arrests result in charges being filed against the perpetrator, and more than half of all prosecutions lead to a criminal conviction (Garner & Maxwell, 2009). However, it is also clear that police in some jurisdictions fail to respond swiftly and decisively to domestic violence calls, allowing dangerous, repeat offenders to continue assaulting

their victims, sometimes with deadly results, and poor interagency coordination and perennial manpower deficits too often result in the under-enforcement of restraining orders (Buzawa & Buzawa, 2002; Seave, 2006). Furthermore, victim services remain underfunded, and this is particularly the case for straight men and lesbian, gay, bisexual, and transgender (LGBT) victims, who encounter institutional biases that inhibit their ability to secure needed housing, legal, mental health, and support services (Hines & Douglas, 2011).

Several unforeseen problems have also arisen with policies toward perpetrators, both in terms of arrest and prosecution and the counseling/education programs (somewhat pejoratively known as *batterer intervention programs* or BIPs) to which they are typically mandated to attend. In a majority of states, mandatory arrest and pro-arrest laws dictate that law enforcement officers must make an arrest for all domestic violence incidents, regardless of how minor, without any evidence of who committed the offense, and are typically prosecuted according to "no-drop" guidelines. Such policies have led to a dramatic increase in overall arrests (Buzawa & Buzawa, 2002). Unfortunately, many of these have been weak cases involving low-level perpetrators who, as will be discussed in upcoming sections, have treatment needs different from the types of individuals with personality disorder for whom traditional treatment policies were designed. Furthermore, perpetrators are 60% less likely to be convicted in mandatory arrest and pro-arrest states in comparison to those that have kept discretionary arrest policies (Hirschel, 2008). Also troubling is the disproportionate arrest and prosecution of men (Shernock & Russell, 2012) and the fact that men account for 83%–90% of individuals enrolled in BIPs (Cannon, Hamel, Buttell, & Ferreira, 2016; Price & Rosenbaum, 2009), a percentage that does not reflect prevalence rates of partner violence in the general population.

CHARACTERISTICS OF PERPETRATOR PROGRAMS (BATTERER INTERVENTION PROGRAMS)

Keywords: *batterer intervention programs*; *treatment of batterers*; *court mandated batterer programs*; *intervention for intimate partner aggression*

The number of perpetrator treatment programs cannot be known with certainty, given that the number and location of these programs, depending on the state, are not always available. In the process of gathering contact information for the most recent national survey on BIPs (Cannon et al., 2016), the authors identified 3,246 programs in the United States based on current lists available on various websites (primarily government websites or state affiliates of the National Coalition Against Domestic Violence [NCADV]). However, up to 65% of the addresses were incorrect, and there may have been some duplication between regular mail and e-mail lists. Assuming that many programs have recently moved, and a current address is simply unavailable, the actual number of programs can be estimated to be somewhere between 1,100 and 3,000.

The Cannon et al.'s (2016) survey consisted of an in-depth, 15-page questionnaire, completed by 238 BIP directors. The large majority of program facilitators (87%) identified as White. The average program serves 105 clients, and about half reported being part of a larger counseling or social service agency, 29% in private practice, and 23% affiliated with a shelter. In 40% of these programs, English is the only language used, and 13% provide services in both English and Spanish. The programs reported to have mostly "excellent" relationships with the courts, law enforcement, social services, shelters and victim advocacy organizations, mental health, and substance abuse programs. Most of the programs provide other services to perpetrators in addition to perpetrator intervention, for example, crisis management (60.7%), parenting classes (53.3%), and substance abuse counseling (50.7%).

According to Rosenbaum and Kunkel (2009), perpetrator treatment programs developed as grassroots or therapeutic approaches. The central emphases of the grassroots approaches were on protection of female victims, stopping violence of males, helping men understand how they use power and control tactics in interactions with their partners, and encouragement of men taking responsibility for any aggression against a partner regardless of perceived precipitants of the aggression. In contrast, the therapeutic approaches emanated from the mental health professions and they approached the men as clients or patients, they addressed individual problems as they impacted on IPV, and they dealt with the dynamics of the relations the men had with their partners, and, not surprisingly, as was the case for the grassroots approaches, the therapeutic approach addressed protection of women. Although there are some clear differences in emphases in the grassroots and therapeutic approaches, the states have had influences over the BIPs such that according to Rosenbaum and Kunkel (2009), almost all programs supported by public funding focus on power and control issues, and 75% of states specify that the BIPs address some form of power and control. Thus, mental health approaches that address issues of aggression in relationships, individual problems, and relationship dynamics have been much less influential than those grassroots approaches that emphasized power and control models.

Duluth Model

The Duluth model originated in Duluth, Minnesota, and was formulated under feminist and sociological frameworks. From an ecological perspective (Bronfenbrenner, 1979), this model is focused on macrolevel social factors, patriarchal cultural norms, and how they influence behavior at the family and individual levels. A web-based survey of 276 perpetrator programs in 45 different states, 53% of them indicated that they operate under a Duluth philosophy (Price & Rosenbaum, 2009). In the United States, Cannon et al. (2016) reported that the Duluth model is the primary treatment approach reported by 35.6% of programs, and the secondary treatment approach reported by 11.7% of programs. Its perpetrator treatment component is psychoeducational in nature, does not subscribe to a therapeutic theoretical framework, and

occurs in a group format. The crux of the Duluth intervention is to illuminate underlying beliefs held by men about their privilege in society and the unequal, subservient position they believe women should maintain (S. Miller, 2010; Pence & Paymar, 1993). The Duluth model includes representations such as the "power and control wheel," which elucidates the patriarchal actions men employ to control women. These tactics include the use of intimidation, isolation, and other forms of psychological or physical abuse. Thus, a primary goal of Duluth intervention is to foster an egalitarian mindset in men about their position in society relative to women.

Evidence is mixed for the centrality of patriarchal structures and attitudes as IPV risk factors. It is generally accepted that these are more salient in developing countries (Esquivel-Santovena, Lambert, & Hamel, 2013) but less so in the United States where research has not found a clear correlation between gendered beliefs and IPV perpetration (e.g., Sugarman & Frankel, 1996). Furthermore, even in more traditional societies, where patriarchal structures are firmly established, cultural attitudes have been found to be only one of several risk factors that include mental health issues, substance abuse, violence in one's childhood of origin, and financial stress (Esquivel-Santovena et al., 2013). In any case, the Duluth model does not emphasize ways to change anger arousal that contributes to domestic violence, differentiating personality types among perpetrators, or previous life events (e.g., trauma, victimization) that may contribute to violence perpetration subsequently (Gondolf, 2007). Proponents of the Duluth model do not view the curriculum as a "treatment" but rather an intervention that is one component of an overarching community response to eliminating domestic violence. Joint efforts from clinicians, researchers, law enforcement, and criminal justice officials are considered imperative for addressing the problematic consequences of domestic violence.

Psychotherapeutic and Cognitive-Behavioral Therapy Model

Although 26% of the perpetrator program directors surveyed by Price and Rosenbaum (2009) characterized their approach as "therapeutic," the distinction between these programs and cognitive-behavioral therapy (CBT) is not very clear. Saunders (1996) reported on an outcome study finding a process-oriented group to significantly reduce rates of recidivism among men diagnosed with depression. To the extent that programs featuring a Motivational Interviewing (MI) component are therapeutic, there is added empirical support for the effectiveness of these approaches, as discussed in an upcoming section of this article.

Cognitive-behavioral interventions for reducing domestic violence assume that violent individuals endorse distorted thinking about self, partner, and the utility of violence in times of conflict (Banks, Kini, & Babcock, 2013; Wexler, 2000). Cannon et al. (2016) found this model to be the primary treatment approach for 29.1% of programs, and the secondary approach for another 25%. In a European study of 54 BIPs in 19 countries, the majority (70%) indicated that they used cognitive-behavioral principles (Hamilton, Koehler, & Lösel, 2012). These interventions place emphasis

on determining the function of violent behavior and typically occur in a group format (Adams, 1988). In addition, the role of anger arousal on the pathway to IPV is emphasized in CBT. Intimate partner violent men display increased trait anger, hostility, outward expression of anger, and inhibited anger control (Holtzworth-Munroe, Rehman, & Herron, 2000). Within this framework, maladaptive thinking patterns surrounding anger, which lead to more insulting and belligerent behavior in domestically violent men, are remedied through cognitive reappraisal and rehearsal techniques for managing anger (Eckhardt, 2007).

The main components of this type of intervention include strategies that target thoughts, emotions, and behaviors and are conveyed through a mixture of psychoeducation, homework assignments, cognitive reframing, and self-esteem enhancement (Palmer, Brown, & Barrera, 1992). Interpersonal deficits are also targeted through a skills training approach. Proponents of this intervention conceptualize interpersonal deficits in terms of heightened sensitivity to situations that ultimately lead to anger arousal and activate a predisposition to perpetrate violence (Wexler, 2000). This conceptualization has strong support in the empirical literature. Most perpetrators do not, as gender-based models suggest, use violence and other forms of coercion strictly out of a desire to maintain "male privilege" or otherwise dominate their partner:

> We approach IPV from a fundamentally different perspective, though we do not take issue with the view that individuals who are socialized to believe IPV is acceptable are especially likely to engage in such violence behavior. We suggest that many acts of IPV are immediately precipitated by perpetrators acting upon gut-level violent impulses that conflict with their more deliberative and self-controlled preferences for nonviolent conflict resolution. From this perspective, many acts of IPV are caused in large part by momentary failures in self-regulation. (Finkel, DeWall, Slotter, Oaten, & Foshee, 2009, p. 483)

A major part of emotional self-regulation, according to a meta-analytic literature review of 113 studies by Birkley and Eckhardt (2015), is the perpetrator's inability to manage his or her anger:

> Based on the present results, we would advance the conclusion that for some partner abusive individuals, perhaps as many as 50% (Eckhardt et al., 2008; Murphy et al., 2007), anger-related problems are meaningfully associated with IPV perpetration and should be taken into account when designing programming for IPV offenders, regardless of whether the perpetrator is male or female. These findings are also informed by decades-old findings documenting interdependence between males and females' displays of negative conflict behaviors during arguments (Burman et al., 1993; Jacobson et al., 1994; Margolin, 1988), as well a recent research demonstrating that males and females do not differ in their use of controlling behaviors in close relationships (Bates et al., 2014; Graham-Kevan & Archer, 2009), countering claims from some researchers that

> women's use of IPV is defensive and noncoercive in nature (Gondolf, 2007). Furthermore, recent research using dialing reporting methods to assess anger and IPV-related behaviors supports the notion that increases in angry affect are associated with increases in IPV risk for *both men and women* (Crane & Eckhardt, 2013a; Elkins, Moore, McNulty, Kivisto, & Handsel, 2013). (p. 52)

Various traditional CBT-related approaches have been found helpful for such perpetrators. Through systematic desensitization, offenders can learn to habituate to previously anger-inducing stimuli in their environments and use cognitive and/or behavioral tools (e.g., communication, assertiveness, and social skills) to refrain from ineffective reactions to stressors (Babcock, Green, & Robie, 2004). Dialectical behavior therapy (Fruzzetti & Levensky, 2000), which combines affect regulation with behavior change, has shown promise as well as approaches that use mindfulness mediation techniques such as Mind-Body Bridging (Tollefson & Phillips, 2015; Tollefson, Webb, Shumway, Block, & Nakamura, 2009), or mindfulness in combination with values-directed goal setting (acceptance and commitment therapy (ACT); Zarling, Lawrence, & Marchman, 2015).

THE COORDINATED COMMUNITY RESPONSE

Individuals who are arrested and prosecuted on a domestic violence charge automatically become part of a system larger than the program to which they are assigned. Regardless of whether or not a perpetrator program is a small solo practice, part of a battered women's shelter, or subsumed within a large social service agency with extensive connections to the community, programs cannot operate entirely independently nor should they (Buzawa, Buzawa, & Stark, 2012; Gondolf, 2012). The courts and probation departments who adjudicate domestic violence cases and monitor offender compliance depend on programs, at a minimum, to send regular progress reports and notify them when it appears that a client poses a threat to the victim. In turn, providers can rely on these outside actors to help facilitate contact with the victim, given research showing victim reports to generally be more reliable than rearrests in predicting recidivism (Nicholls, Pritchard, Reeves, & Hilterman, 2013). Furthermore, courts and probation can serve as the "heavy" and hold perpetrators them legally accountable, which in itself has been shown to increase compliance and reduce rates of recidivism, allowing providers to focus on the needs of their clients and develop the therapeutic bond necessary for successful treatment outcomes (Eckhardt et al., 2013). To the extent that programs have good relationships with probation, there is a possibility of mutual learning. Although they possess the power to have offenders summarily remanded to police custody, probation officers often take on a dual approach to offender work, acting as both authority figures and concerned helper, willing to treat each client fairly and in a just manner (Kennealy, Skeem, Manchak, & Eno Louden, 2012).

Findings from the research literature are mixed with respect to the effectiveness of intensive court monitoring, including special domestic violence courts, in reducing

rates of IPV recidivism. In Lexington County, South Carolina, a court was established to specifically handle misdemeanor domestic violence cases:

> The findings from the logistic regression model and the predicted probabilities indicate that being processed through the criminal domestic violence court significantly reduced the likelihood that an individual would be re-arrested for a domestic violence offense in an 18 month follow-up period. This effect is not the result of different types of offenders being processed during the two time periods. Therefore, it appears from the available data that the domestic violence court has a significant inhibitory effect on the likelihood of re-arrest compared to the traditional magistrate court's approach to handling domestic violence cases. (Gover, MacDonald, Alpert, & Geary, 2003, pp. 88–89)

Intensive court monitoring and probation case management has been found effective in increasing treatment success for substance abusers (e.g., Siegal, Li, & Rapp, 2002), and there is evidence, albeit tentative, that these procedures may also be effective with domestic violence cases. Gondolf (2000), for example, conducted a study of 321 cases involving men ordered to 12 weeks in a BIP by the domestic violence court in Pittsburgh to determine the effects of court monitoring on program completion. Results indicate that an increase in the number of offender court reviews decreased program attrition rates from 52% to 35%. A multisite study was conducted by Urban Institute of Washington (Visher, Harrell, & Yahner, 2008) using quasi-experimental and pretest–posttest designs. Based on victim reports, recidivism rates were lowered in Massachusetts but not in Michigan, whereas recidivism rates based on police reports of rearrest were found for the Milwaukee site but not in Michigan or Massachusetts.

According to L. Stewart, Flight and Slavin-Stewart (2013),

> In the effective corrections literature . . . one meta-analysis showed that 300 hr are needed to result in a reduction of recidivism from 59% to 38% for high-risk offenders with multiple needs and 200 hr of service for moderate risk with moderate needs was sufficient to reduce recidivism from 28% to 12%. For high- and moderate-risk offenders with a moderate number of criminogenic needs, 200 hr of treatment was sufficient to reduce recidivism from 44% to 30% (Bourgon & Armstrong, 2005). Lipsey's (1995) earlier meta-analysis suggested 100 hr were needed for high-risk offenders, but these studies were largely derived from juvenile samples. The average intensity level for DV programs in the literature is around 20 sessions (approximately 40 hr), far short of what is suggested as necessary for high-risk offenders. In addition to direct program service, the highest risk offenders require a coordinated case management strategy that monitors the safety of potential victims by active contact and assistance and by proactive arrest policies where there is evidence of escalation in dynamic risk. Specialist high-risk offender management teams in some police forces in the United States and Canada are excellent models of this strategy. (pp. 500–501)

Mention was made in a recent literature review (Eckhardt et al., 2013) of the randomized controlled trial (RCT) of intensive judicial monitoring of domestic violence offenders that was handled in two separate domestic violence courts in Rochester, New York (Labriola, Cissner, Davis, & Rempel, 2012). Because judicial monitoring is often seen as a central aspect of BIPs, it seemed important to discuss an RCT of such. In Labriola et al.'s (2012) study, judicial monitoring referred to frequent ongoing court appearances to verify and motivate offender compliance with court-mandated conditions. Overall, there was no evidence to support a positive impact of court monitoring. Assignment to judicial monitoring did not have an impact on rearrests, program attendance, or program completion. However, judicial monitoring did affect offender perceptions in that they were more likely to understand their obligations and know that there would be consequences for noncompliance and that the consequences would be severe compared to offenders not assigned to judicial monitoring. Overall, the results suggest that more frequent judicial monitoring can have some beneficial effect in that perceptions of consequences of noncompliance and perceptions of procedural justice were associated with attending more sessions.

Aside from the criminal justice system, BIPs must at times interface with various other community organizations and agencies to fully address the needs of their clients, among them unemployment, serious mental health issues, substance abuse, and child care. The multisite study of BIPs conducted by Gondolf (1999), previously cited, reported that perpetrators enrolled in programs which actively reached out to victims and offered perpetrators individual counseling, substance abuse treatment (or referrals), and legal or educational support subsequently engaged in less severe and less frequent violence after treatment. The importance of case management and coordination with the community has been well articulated by Cantos and O'Leary (2014):

> Given that most of the generally violent men frequently also score positive on what have been referred to as underclass variables such as unemployment and low income (Bennet, Hsieh, Huss, & Ralston, 2008; Cantos et al., 2013), it would be important to address these underclass variables prior to the intervention proper. Maslow's work would suggest that it would prove difficult to have these men attend to therapeutic intervention when other more basic needs are left unattended (Maslow, 1954). Interventions directed at increasing stake in conformity variables for this group of men would appear to be common sense preconditions for these perpetrators to be able to benefit from these groups. For example, assistance in job training and/or job placement could assist a man to feel better about himself and his ability to care for others, including his children. Once some attention has been given to these variables and the perpetrator's motivation to remain free of court sanctions has been increased, it would then be possible to provide these men with anger control and impulse control skills training as well as conflict resolution skills. (p. 221)

TABLE 1. Case Management and Referral Services Provided by Batterer Intervention Programs in the United States and Canada

Crisis management	60.7	Career services	8.7
Parenting classes	53.3	Housing	8.0
Substance abuse counseling	50.7	Police/safety	8.0
Educational resources	38.0	Job training	8.0
Community advocacy	24.7	Clothing	7.3
Mentoring	12.7	Financial	6.0
Food	10.0	Employment	5.3
Transportation	9.3		

Data from the Cannon et al.'s (2016) survey indicate that BIPs, on the whole, provide more than therapy or a psychoeducational group experience, as indicated in Table 1.

Overall, BIP directors and facilitators appear to be satisfied with their community-wide relationships. The percentage who report to having good or excellent relationships with the courts are at 90.1%; for advocacy organizations such as battered women's shelters, the percentage is 86.8%; and 81.2% say they have a positive relationship with law enforcement (Cannon et al., 2016).

EXISTING STATE STANDARDS FOR PERPETRATOR PROGRAMS

Search: conducted through Google.com, PsycINFO database, and Google Scholar database
Keywords: *batterer intervention programs*; *court-mandated treatment*; *state standards*

Maiuro and Eberle (2008) engaged in an in-depth review of state standards for BIPs across the United States, concluding that despite significant debate about the utility of such standards, 45 of the 50 U.S. states currently have state standards written into legislation. Although a number of years have passed since their review and conclusions, there have been no major changes in state standards. The five states that do not have any standards for perpetrator treatment are Arkansas, Connecticut, Mississippi, New York, and South Dakota. Although Connecticut does not currently have standards, House Bill 7005 was introduced on March 11, 2015, proposing that the Criminal Justice Policy Advisory Commission establish a subcommittee on domestic violence offender program standards. This bill suggests that these standards be placed on all BIPs operating in the state of Connecticut.

Maiuro and Eberle (2008) examined state standards on a host of different categories such as processes of certification, risk assessment protocols, length of treatment, theoretical framework, incorporation of research, treatment methods, and protocol for revising standards. Results suggest that 65% of states employ representatives from victim programs and other agencies, creating multidisciplinary and cross-agency committees, which create and oversee standards for BIPs, whereas 23% regulate these standards through health and social agencies. Although some states codify these standards into law, others maintain these standards simply as guidelines.

Furthermore, 76% of states describe treatment approach, content, and methodology with 95% operating under the philosophical framework that partner violence stems from patriarchal factors of power and control. Sixty-eight percent of those states recognize that power and control are not the sole causes of violence, also giving a nod to social psychological factors (attitudes toward women, skill deficits, violence in the family of origin). Unfortunately, only 5% of states rely on state-of-the-art evidence-based models of partner violence (cognitive-behavioral models). Although few states mandate evidence-based treatments, 67% of states suggest intervention in multiple areas of functioning beyond power and control dynamics (Maiuro & Eberle, 2008).

Regarding duration, Maiuro and Eberle (2008) note that most states dictate that treatment should last for a minimum of 6 months (62%), and 98% suggest a modality of group therapy, with 91% mandating one uniform treatment for all patients, regardless of information gleaned from an initial assessment (i.e., One Size Fits All). Notably, this type of uniform treatment has been criticized for effectiveness, with evidence suggesting that heterogeneous and specialized treatments may be more effective in preventing future violence (Cantos & O'Leary, 2014).

Consistent with psychological research, most state standards require that patients must not be using alcohol or substances during treatment, and suggest screening for substance abuse (alcohol included). However, very few states use standardized and validated measures of substance abuse in their protocol, suggesting that most states recognize alcohol and substance abuse as a significant issue but have neglected to incorporate proper methods of assessment (Maiuro & Eberle, 2008).

Most state standards discussed herein (75%) are composed of documents that neglect to use empirical evidence to support their assertions. Notably, only 25% of state standards provide references, and often these references are either outdated or very infrequently integrated. Moreover, most states do not engage in program evaluation or effectiveness (Maiuro & Eberle, 2008).

As Maiuro and Eberle (2008) note, psychological science is still in the process of developing and testing interventions for violence and aggression; the field has not yet agreed upon a single process or method of intervention. Of course, the goal of these standards is to improve the efficacy of treatment programs, which have the potential to be ineffective if not regulated. To evaluate the utility of standards in achieving the goal of impacting intervention practices, Boal and Mankowski (2014) evaluated change before and after the adoption of state standards in Oregon, finding that the use of mixed-gender groups increased, but other practices were largely unchanged. Although standards address specific issues such as increased community collaboration, and requirements for completion of the programs, changes in these domains were inconsistent or in the opposite direction after the standards were instituted; these findings suggest that there may be a lack of compliance with state standards, even when they do exist. This new work highlights the need for continued attention to not only the content of these state standards but also the practices and compliance of programs. Table 2 lists the websites associated with state standards for BIP for all 50 U.S. states.

TABLE 2. State Standards

1. Alabama: http://acadv.org/training-programs/perpetrator-intervention-programs/
2. Alaska: http://www.dps.state.ak.us/Cdvsa/Services-For-Men-Who-CommitDV.html
3. Arizona: http://www.azdhs.gov/phs/owch/women/domestic-violence/documents/az-service-standards-domestic-violence.pdf
4. Arkansas: no BIP standards
5. California: http://www.courts.ca.gov/documents/batterer-report.pdf
6. Colorado: https://sites.google.com/a/state.co.us/dcj-domestic-violence/home/about-us
7. Connecticut: No BIP standards; however, there is a bill that is currently being considered (https://legiscan.com/CT/text/HB07005/2015).
8. Delaware: http://dvcc.delaware.gov/offender_intervention.shtml
9. Florida: In 2012, Department of Children and Families is no longer required to certify programs by the state; however, several standards still remain such as length of sessions, power and control theme, funding and preferred programs (http://www.myflfamilies.com/service-programs/domestic-violence/batterer-intervention-program).
10. Georgia: http://www.gcfv.org/index.php?option=com_content&view=article&id=5&Itemid=5
11. Hawaii: http://www.ncdsv.org/images/HI_BIPS-Standards_December2010.pdf
12. Idaho: http://icdv.idaho.gov/dv-standards-resources.html
13. Illinois: http://tigger.uic.edu/~lwbenn/DVPEP/JnlAMT.htm
14. Indiana: http://www.icadvinc.org/batterers-intervention-programs/
15. Iowa: http://www.biscmi.org/other_resources/docs/iowa.html
16. Kansas: http://ag.ks.gov/victim-services/bip
17. Kentucky: http://chfs.ky.gov/dcbs/dpp/battererintervention.htm
18. Louisiana: Task force for BIP standards developed in 2011—http://lcadv.org/wp-content/uploads/DAIP-Report-to-Legislature-02-20-12.pdf Maine
19. Maine: http://www.maine.gov/corrections/VictimServices/BatIntervent.htm
20. Maryland: http://www.biscmi.org/other_resources/maryland.pdf
21. Massachusetts: http://www.mass.gov/eohhs/provider/licensing/programs/batter-intervention-services/guidelines.html
22. Michigan: http://www.biscmi.org/aboutus/michigan_standards.html
23. Minnesota: https://www.revisor.mn.gov/statutes/?id=518B.02
24. Mississippi: no official BIP standards; the Center for Violence Prevention has received funding to run Duluth model groups—http://mscvp.org/batterers-intervention/
25. Missouri: http://www.biscmi.org/other_resources/BIP_Service_Standard_June_2006.pdf
26. Montana: The offender shall complete all recommendations for counseling, referrals, attendance at psychoeducational groups, or treatment . . . The counseling provider must be approved by the court, minimum of 40 hours, must be with a professional person or in a specialized domestic violence intervention program (http://leg.mt.gov/bills/mca/45/5/45-5-206.htm).

(Continued)

TABLE 2. State Standards *(Continued)*

27. Nebraska: http://ndvsac.org/dv/batter-intervention-program/
28. Nevada: http://www.biscmi.org/other_resources/docs/nevada.html
29. New Hampshire: http://endingtheviolence.us/standards.htm
30. New Jersey: http://www.biscmi.org/other_resources/nj_bip_stds.pdf
31. New Mexico: http://www.nmcadv.org/batterer-intervention-programs-training-and-standards/
32. New York: no BIP state standards
33. North Carolina: http://www.nccfwdvc.com/programs.aspx?pid=ab
34. North Dakota: http://cawsnorthdakota.org/wp-content/uploads/2014/09/BT-Standards-2011-CAWS.pdf
35. Ohio: http://www.odvn.org/training/Documents/BI_Standards_2010__Final3_Ohio.pdf
36. Oklahoma: http://www.ok.gov/oag/documents/Title%2075-15%20%20DVSA%20Effective%209-12-2014.pdf
37. Oregon: standards since 2006—http://www.doj.state.or.us/victims/bip_advisory_committee.shtml
38. Pennsylvania: no BIP standards
39. Rhode Island: http://sos.ri.gov/documents/archives/regdocs/released/pdf/BIPSOC/4993.pdf
40. South Carolina: https://dss.sc.gov/content/customers/protection/dv/scbt.pdf
41. South Dakota: no BIP standards
42. Tennessee: http://www.state.tn.us/sos/rules/0490/0490-01.pdf
43. Texas: http://www.tcfv.org/pdf/guidelines.pdf
44. Utah: http://www.biscmi.org/other_resources/docs/utah.html
45. Vermont: http://www.vtnetwork.org/about/wpcontent/uploads/Vermont_Signed_BIP_Standards1.pdf
46. Virginia: http://www.vabipboard.org/assets/bipstandards.pdf
47. Washington: http://www.kingcounty.gov/courts/Clerk/DomesticViolence/DV4_0.aspx
48. West Virginia: http://www.legis.state.wv.us/wvcode/ChapterEntire.cfm?chap=48&art=26
49. Wisconsin: http://www.wcadv.org/sites/default/files/resources/WBTPA%20_Standards_2007.pdf
50. Wyoming: http://www.biscmi.org/other_resources/DoVE_Council_BIP_Intervention_Standards_Final_02_18_10.pdf

FINDINGS FROM THE RESEARCH LITERATURE

Methodology Used for This Article

In May 2014, the senior editor for the journal *Partner Abuse* and one of this article's coauthors invited research scholars with expertise in the field of domestic violence and perpetrator intervention to conduct research on the characteristics and

effectiveness of BIPs and based on this research to make recommendations for a proposed set of evidence-based national standards. The coauthors of this article are nationally recognized experts in the field.

The article is divided into three sections. The introduction provided a general overview of IPV as a social and mental health problem, including prevalence rates, context, risk factors, and consequences; current policies on IPV intervention; and a summary of the role of perpetrator treatment programs in the criminal justice response to domestic violence, their characteristics, and the limitations of the state standards by which they are regulated. As illustrated in Table 3, the second section will examine the social science literature in a multitude of key research areas, providing much greater detail about the effectiveness of these programs.

For this section, the authors were instructed to conduct a thorough search of the social science literature and to indicate the search engines and keywords used. In reporting on the studies they investigated, they were asked to provide a preliminary analysis of the evidence and distinguish among their findings the most methodologically sound. In general, reliable evidence is most likely to come from individual random assignment to conditions (RAC) studies, or even better, meta-analyses of RAC studies; and secondarily, from quasi-experimental designs such as controlled studies without randomization, using nonequivalent control groups or a pretest–posttest design.

The recommendations made in the third section are based primarily on those findings. In areas where experimental findings are scant or nonexistent, some consideration is given to the literature on risk factors for domestic violence perpetration and to relevant outcome findings on related populations (e.g., general psychotherapy clients, substance abusers, non-IPV criminal offenders), and, to a much lesser extent, the clinical experience of BIP directors polled in a recent nationwide survey.

TABLE 3. Research Areas

Overall effectiveness of batterer intervention programs
Length of treatment/length of group sessions
Number of group participants and number of facilitators
Group format and curriculum
Assessment protocol and instruments
Victim contact
Modality of treatment
Differential treatment
Working with female perpetrators
Working with perpetrators in racial and ethnic minority groups
Working with lesbian, gay, bisexual, and transgender perpetrators
Perpetrator treatment and practitioner–client relationships
Required practitioner education and training

Overall Effectiveness of Batterer Intervention Programs

The evidence of effectiveness of BIPs has been debated for years with little clear documentation that such programs work (e.g., Feder & Wilson, 2005; Maiuro & Eberle, 2008). At best, one may argue that BIPs may have significant but very small effects (Babcock et al., 2004). More specifically, Babcock et al. (2004) indicated that someone in a BIP is only 5% less likely to perpetrate physical aggression toward a female partner than a man who has only been arrested and sanctioned.

To make statements about the effects of BIPs, one has to take into account that the BIPs are generally compared to the effects of being placed on probation and being visited periodically by a probation officer. Thus, questions about BIPs do not address the question of whether the BIP has any effect. Rather, they address the question of whether BIPs have an effect over and above the effects of being placed on probation as in many states men and women arrested for intimate partner aggression usually are placed on probation. This review of BIPs will focus on meta-analytic/empirical reviews of BIPs since that of Babcock et al. (2004) and Feder and Wilson (2005). To compile such reviews, Google Scholar was used as the reference source with the terms *Batterer Intervention Programs*, *treatment of batterers*, *court-mandated batterer programs*, and *intervention for intimate partner aggression*. The most recent reviews of BIPs basically indicate that there is no clear evidence that BIPs are effective, especially if one is referring to traditional BIPs. "Interventions for perpetrators," according to Eckhardt et al. (2013) "show equivocal results regarding their ability to lower the risk of IPV, in part because of widespread methodological flaws, although more recent investigations of novel programs with alternative content relative to traditional programs appear to show promising results" (p. 225).

Eckhardt et al. (2013) found 20 studies that were deemed adequate for a review and 14 of those studies were Duluth-type programs, 4 were CBT-type programs with a therapeutic focus, and 2 with other foci. To be included in the review, the study had to have (a) an intervention for perpetrators, (b) one or more comparisons groups, (c) a measure of recidivism, and (d) published since 1990. Nine of the 20 programs showed significant reductions in partner aggression, but of the 6 studies that had a no treatment control comparison, there were no differences in the recidivism rates and 2 of these 6 studies were Duluth-type programs. Eckhardt et al. indicated that quasi-experimental groups are more likely to show change but as the methodological rigor of a study increases, the likelihood of obtaining significant effects decreases.

Another recent review of this literature by Arias, Arce, and Vilariño (2013) summarized their findings as follows: "On the whole, the treatment of batterers had a positive but nonstatistically significant effect." The review required the following to have a study included: (a) sample size, (b) recidivism rate for treatment completers, (c) recidivism measured by official records as well as by partner/victim report, (d) recidivism measured at a period of at least 6 months, and (e) theoretical rationale and program described. These criteria led to six experimental studies with a control group which were published between 1998 and 2009. The conclusion basically was that

BIPs had a positive but nonsignificant effect and that because some men responded and some do not, as noted earlier, there is a need for the study of moderators of treatment outcome.

In short, neither the earlier nor more recent meta-analytic reviews of traditional BIPs provide convincing evidence of the effectiveness of such programs, especially if the analyses are based on the most rigorous experimental designs. Based on literature reviews of BIP effectiveness, one may conclude that about 66% of men who battered their wives stop doing so as judged by some self-report or partner report measures at 6-month follow-up. With such cessation rates, one might conclude that BIPs are reasonably effective, but one must compare such cessation rates with cessation rates of men who did not participate in a BIP. Therein, a problem is presented as being placed on probation itself or court monitoring could have an effect of helping reduce IPV.

Clearly, the social science literature is replete with very damning criticisms of BIPs, and numerous reviews of BIPs document dropout rates that often range from 40% to 85% (Jewell & Wormith, 2010; Taylor, Davis, & Maxwell, 2001). Still, even the most rigorous outcome research finds *some* treatment effects in terms of reduced rates of recidivism, and the positive testimonials from BIP clients indicate that they see themselves quite differently after being in such programs. In this regard, one must ask what kinds of BIPs work and what kinds do not? There is some evidence that programs based on a CBT model are, overall, somewhat more effective than those based on feminist/power and control models (M. Miller, Drake, & Nafziger, 2013). A better question might be what *specific* interventions across treatment models predict positive treatment outcomes? According to the review by Eckhardt et al. (2013), RAC research suggests that the use of client-centered approaches such as MI, and other techniques aimed at building a facilitator–client alliance, significantly reduce rates of recidivism among individuals court ordered to BIPs. Upcoming sections will examine such intervention in greater detail and investigate promising approaches based on proper assessment procedures and differential treatment.

Length of Treatment and Length of Group Sessions

Search: PsycINFO; Google Scholar; organizer's list of references
Keywords: *batterer intervention*; *domestic violence*; *intimate partner violence*; *length of treatment*; *group length*

To date, there have been relatively few studies on BIPs that include reports on overall length of treatment and length of each group session. However, the length of treatment varies tremendously from state to state and ranges from 8 weeks to 1 year or more (Cannon et al., 2016; Rosenbaum, Gearan, & Ondovic, 2001). A considerable majority of programs mandate a minimum of 24–26 weeks of enrollment in perpetrator treatment (Maiuro & Eberle, 2008). Through a recent survey of programs in the United States and Canada, Cannon et al. (2016) found that the average number of sessions in these programs was 30 (SD = 12.12), with a range from 8 to 78 weeks and

the modal number of sessions being 26 (n = 178). In terms of length of each group session in these programs, responses to the survey by Cannon and colleagues (2016) indicated that the average length of sessions across programs was 103 minutes (SD = 19.1). The modal session duration reported was 120 minutes (n = 184).

A few studies have found greater treatment length to correlate with reduced rates of recidivism. For example, the RAC experimental study by Taylor et al. (2001) found reduced rates of recidivism for men who completed a 26-week group compared to 8 weeks, and the quasi-experimental multisite study (Gondolf, 1999) found significantly lower rates of moderate-severe violence recidivism among men who completed a 9-month group compared to 3 months. However, much different results were reported by Babcock et al. (2004). In their meta-analysis of BIPs, the researchers dichotomized interventions used in their study into two groups based on whether treatment duration was less than or at least 16 weeks. For treatments that were 16 weeks or more, or "long" treatments, they found effect sizes of d = .16 and d = .18 for recidivism reduction based on police report and partner report, respectively. In addition, effect sizes were d = .20 based on police report and d = .30 based on partner report for treatments that were less than 16 weeks, or "short" treatments. These results suggest that shorter interventions—specifically those less than 16 weeks—may actually show larger treatment effects than longer treatments for reducing recidivism among male perpetrators. Unfortunately, because of insufficient power, Babcock and colleagues (2004) were unable to examine treatment length as a moderator of the relation between treatment type (Duluth, CBT, etc.) and recidivism.

Number of Group Participants and Facilitators

Search: PsycINFO; Google Scholar; organizer's list of references
Keywords: *batterer intervention*; *domestic violence*; *intimate partner violence*; *group facilitators*; *group members*; *group participants*; *characteristics*

Currently, there is no universal standard for the maximum number of group members that are permitted in a perpetrator group at any given time. However, these particular numbers vary considerably from state to state. Most states indicate an ideal group would have between 6 and 12 participants and no more than 20 (Stop Abusive and Violent Environments, 2015). In a survey of BIP characteristics in the United States and Canada, Cannon and colleagues (2016) found that the average number of clients per intervention was 8 (N = 166), with a wide range from 1 to 42. The modal number of participants in an intervention at any given time was 10. No experimental studies have been conducted on group size, but clinical experience suggests that group cohesion and a strong client–facilitator alliance, so important for group retention and lower levels of posttreatment violence, may not be possible with larger groups of more than 10.

Programs across the United States also vary in terms of the number of facilitators they have for leading groups. In most cases, two co-facilitators are responsible for leading these groups (Price & Rosenbaum, 2009). The most common arrangement

(approximately one-third of programs) that Price and Rosenbaum (2009) identified in their survey of perpetrator programs in the United States was a male–female co-leader team. The advantageous qualities of a mixed-gender co-facilitation are underscored by the importance of providing male group clients, with opportunities to witness modeling of effective interactions with women and enhancing their exposure to healthy male-female relationships (Boal & Mankowski, 2014). This idea was corroborated in the Cannon and colleagues' (2016) survey when facilitators ($N = 76$) were asked to provide information on how they felt BIPs could be improved. Many revealed that the incorporation of more female co-facilitators would model equality for group members.

Apart from the male–female co-facilitator arrangement, 20% of programs reported that most of their groups were led by a single male leader. In addition, 15% of programs reported that most of their groups were led by a single female leader. The least common scenario they identified (reported by 8% of programs) was that the majority of their groups were facilitated by either two males or two females (Price & Rosenbaum, 2009). No reports of more than two facilitators were made. Furthermore, respondents to the more recent survey by Cannon and colleagues (2016) indicated that their average numbers of female and male facilitators were four and two, respectively. In addition, 87.4% ($n = 188$) of facilitator respondents identified as White, 6.5% ($n = 14$) as African American, 5.1% ($n = 11$) as Hispanic or Latino, 3.3% ($n = 7$) as American Indian or Alaska Native, and 0.5% ($n = 1$) as Asian. Levels of educational attainment varied, ranging from bachelor's degree to doctoral degree, with master's degrees being the most common (65.4%; $n = 85$). To date, there are no experimental studies that have examined the specific effects of different facilitator arrangements (e.g., one male, one female, male–female co-facilitator team), facilitator demographics, or group size on recidivism among perpetrators.

Group Format and Curriculum

Search: PsycINFO; Google Scholar; organizer's list of references
Keywords: *batterer intervention*; *Duluth*; *cognitive-behavioral*; *couples*; *domestic violence*; *group format*; *curriculum*

Intervention groups for perpetrators of domestic violence are administered through various mechanisms but most involve a combination of psychoeducation, discussion, and group exercises. As reported in the Cannon et al.'s (2016) national BIP survey, nearly all programs use handouts and exercises (96.2%) as well as a discussion, or "check in" time (94.1%). About 70% use some form of media, such as DVDs, nearly two-thirds use role-play exercises, and a smaller percentage (42.7%) have clients keep written journals or progress logs. Psychoeducation typically takes the form of lectures.

The amount of group time devoted to instruction versus discussion among programs is not known, and no research has been conducted comparing the relative merits of each. Hamel (2014) divides his 2-hour groups into an initial check-in/discussion

period of approximately one hour, followed by a presentation of didactic material and exercises in the second. How much time each person spends during his or her own "check-in" depends on the number of people in the group, and on the nature of his or her share. Group facilitators are advised to be flexible, more generous with anyone who is in crisis, who is sharing about some significant treatment progress, or is demonstrating a newfound honesty and depth of sharing not seen before. In such cases, the open discussion period can spill over into the second hour. In the second hour, the leader presents the course material for that week, either by summarizing the material using the white erase board, asking the group members to take turns reading directly from the workbook. The curriculum material consists of 16 lessons, repeated three times during the course of 52 weeks (Weeks 1–17, 18–34, and 35–52). Each 16-week lesson block is divided into three modules (Causes and Consequences, Emotion Management, Building Relationship Skills). Although the basic lessons remain the same across blocks, the in-class worksheets vary. Individuals enrolled for only 16 weeks are thus exposed to the core elements of the program, whereas those enrolled for the full 52 weeks benefit from the repetition as well as the added material.

A recently developed couples-based intervention based on the Creating Healthy Relationships Program (CHRP) also uses video vignettes to prompt self-reflection on topics related to communication, conflict management, and intimacy among couples, to name a few. However, in this case, couples in the group watch videos of other couples discussing relationship topics (Bradley, Friend, & Gottman, 2011). Typically, after a video vignette is shown or psychoeducation on a particular topic is completed, there is a transition into a discussion format between participants and facilitators, which may or may not be paired with in-group exercises to solidify previously acquired knowledge and skills.

As would be expected, the content of the lectures vary based on the theoretical orientation of the particular intervention. For instance, lectures in a Duluth intervention would normally focus on the importance of reversing patriarchal and controlling views of women in society perhaps through an examination of the "power and control wheel" (Pence & Paymar, 1993). Duluth interventions incorporate video vignettes into their curricula: Male group members are required to watch these vignettes, which depict a male offender being abusive toward a woman. This strategy is intended to facilitate the men in group to think reflectively and critically about how similar situations, intentions, and beliefs to those portrayed in the videos may lead to violence perpetration in their own lives (S. Miller, 2010).

On the other hand, a cognitive-behavioral intervention would likely contain lectures that prioritize skills building related to deficits in areas such as communication strategies, anger management techniques, and relaxation training. Such interventions might require clients to complete logs and exercises intended to help them identify and challenge their pro-violent and irrational thoughts necessary for managing strong emotions (Eckhardt, 2007; Hamel, 2014; Wexler, 2013). More cutting-edge interventions incorporate into their lectures information about aggression and brain processes and devise homework assignments accordingly (e.g., Potter-Efron, 2014, 2015). Regardless of their theoretical orientation, programs are more successful

when participants make use of in-class exercises and "homework." Among the more robust predictors of treatment failure, along with poor attendance, are a client's refusal to participate in group activities or to complete homework assignments (e.g., see Gondolf & Wernik, 2009). On the other hand, there is evidence from one CBT outcome study that homework compliance predicts lower levels of psychological abuse after treatment (Taft, Murphy, King, Musser, & DeDeyn, 2003).

Cannon et al. (2016) obtained descriptive data on group structure and format from program representatives that responded to their survey. They found that most interventions (97.3%; $N = 183$) were delivered via group therapy. Intervention programs incorporate a wide array of educational components, skills, and techniques into their curricula. Most commonly, 97.3% ($N = 181$) of programs elucidate the effects of violence on children, 94.6% ($N = 176$) highlight the relevance of power and control tactics, and 83.9% seek to raise consciousness about gender roles. More than 80% teach emotion management, conflict resolution, self-awareness, and general coping skills and help clients identify and change pro-violent and irrational beliefs. Fewer programs, but still a majority, teach anger management and impulse control skills (75.3%), assertiveness training (62.4%), or meditation and relaxation techniques (57.0%). Less than half said they offered grief work, helped clients to identify mutual abuse cycles, or provided them with skills to heal past trauma (Cannon et al., 2016).

This data tell us, of course, only *what* BIPs are doing, not what they *should* be doing. Known risk factors should provide an initial basis on which to identify and assess potential educational components. As previously discussed in the introductory section of this article, research has identified several risk factors to be associated with perpetration of IPV. The following are the more significant risk factors and the education components that might be used to address them, along with some of the relevant research.

1. *Risk factor: Stress, especially from low income and unemployment*
   Education components: Teach relaxation and meditation exercises. Help clients acquire the communication and problem-solving skills with which to resolve or lessen the problems that cause stress. Teach clients about the importance of good physical health and lifestyle balance.
   Research: Between a fourth and a third of individuals currently enrolled in BIPs are unemployed (Cannon et al., 2016). The CBT programs determined to have been the most effective in reducing IPV recidivism feature stress reduction components in their curriculum (Babcock et al., 2004; Eckhardt et al., 2013).
2. *Risk factor: Having an aggressive personality characterized by a desire to dominate, hostility toward the opposite sex or attitudes that support violence*
   Education components: Challenge clients to examine their antisocial and/or sexist attitudes by providing information about healthy relationships. Have them complete exercises that help them figure out for themselves how their aggressive behaviors undermine their ability to get their own needs met. Teach ways of overcoming jealousy increasing empathy for others.

Research: Given the lack of correlation between male perpetrators' sexist, traditional sex role beliefs and IPV perpetration (Sugarman & Frankel, 1996), the Duluth focus on patriarchy and gender roles appears to be misplaced. However, the same authors determined in their meta-analysis that pro-violent attitudes do in fact predict relationship violence, findings also reported by Capaldi et al. (2012) in their review of the literature and by the National Family Violence Survey (Chan & Straus, 2008). Furthermore, identifying, disputing, and altering cognitive distortions irrational beliefs of all types is a central component of effective CBT programs (Babcock et al., 2004; Eckhardt et al., 2013).

3. *Risk factor: Poor impulse control*
   Education components: Educate clients about the function of human emotions, including the positive and negative functions of anger. Explain findings from brain science relevant to poor impulse control. Teach clients about the cognitive distortions that maintain anger impulses and prevent responsibility taking, such as the "ventilation myth," which holds that one can successfully discharge anger by, for example, pounding on a pillow. Have clients keep CBT journals with which to better understand the interconnection between thoughts, feelings, and behavior.
   Research: An outcome study by Hamberger and Hastings (1988), using a pretest–posttest design, found that men who reported lower levels of anger after completing sessions in anger management perpetrated reduced levels of IPV at a 1-year follow-up. Similar results had previously been found by Saunders and Hanusa (1986), with male IPV offenders who completed a 20-week process/CBT group with an anger management component.
4. *Risk factor: Depression*
   Education component: Help clients understand that depression is a mental health disorder, usually treatable by a combination of psychotropic medication and therapy. Provide them with community resources, such as local mental health centers.
   Research: Effective treatments for depression, primarily in the form of CBT and/or medication management, have been documented in numerous studies and available to the general public through the Cochrane reviews (http://www.cochrane.org/search/site/depression?f[0]=bundle%3Areview).
5. *Risk factor: Emotional insecurity*
   Education component: Inform clients about the difference between secure and insecure attachment. Teach them about the universal human needs and each person's responsibility to meet them without aggression or violating other people's personal boundaries. Teach emotion management, communication, assertiveness, and conflict-resolution skills.
   Research: No outcome research has yet been published on interventions that specifically target insecure attachment or emotional dependency. However, as indicated elsewhere in this section, research has documented the effectiveness of stress reduction, anger management, and relationship-building skills.

6. *Risk factor: Alcohol and drug abuse*
   Education component: Inform clients about the effects of alcohol and other mind altering substances, especially the relationship between substance abuse and domestic violence.
   Research: Professional and self-help programs are available in most localities. Web-based organizations (e.g., http://www.addictionrecoveryguide.org/) provide information about treatment options as well as provide information about best practices in intervention (e.g., http://www.samhsa.gov/ebp-web-guide/substance-abuse-treatment).
7. *Risk factor: Having witnessed violence between one's parents as a child, or having been abused or neglected by them*
   Education component: Through handouts, exercises, and group discussion, help clients identify and overcome the abusive and dysfunction patterns of behavior they may have learned from their childhood of origin. Teach about the toxic effects of shame on a person's personality, leading to self-destructive behaviors and interpersonal aggression. Help them understand the effects of trauma on the brain and human development. Educate them about the effects of domestic violence on children and teach positive parenting skills.
   Research: One of the more well-known psychotherapeutically oriented programs for male IPV perpetrators is the Compassion Workshop in the state of Maryland, which focuses on clients' childhood of origin and issues of shame and trauma (Stosny, 1995). In one study, Stosny (2005) low client dropout rates and significant decreases in physical and emotional abuse were found among men who were provided emotion management skills with which to overcome shame-based anger. In another (Stosny, 1994), men presented with a video of a resistant offender as a boy witnessing his father assault the mother were significantly more likely to complete homework assignments and finish the group compared to the men not shown the video.
8. *Risk factor: Being in an unhappy or high-conflict relationship*
   Education component: Educate clients about all of the various domestic violence dynamics—not just the three-phase cycle originally identified by L. Walker (1983). Various types of mutual cycles exacerbate conflict and violence and maintain interpersonal dependency. Teach them communication, conflict-resolution, and other relationship-building skills.
   Research: Controlled laboratory experiments with partner violent individuals and their partners have consistently found increases in relationship aggression when conflicts mutually escalated and have identified patterns of negative reciprocity, attack–defend and demand–withdraw (e.g., Babcock, Waltz, Jacobson, & Gottman, 1993; Burman, John, & Margolin, 1992; Cordova, Jacobson, Gottman, Rushe, & Cox, 1993; Margolin, John, & Gleberman, 1993; Ridley & Feldman, 2003). In one study using dating samples (Cornelius, Shorey, & Beebe, 2010), poor communication and conflict resolution skills predicted both emotional and physical abuse.

In Babcock et al.'s review of the literature (2004), a program focused on building relationship skills for partner violent men was deemed one of the more successful interventions available, but reduced rates of recidivism have also been found in various CBT-based programs that teach communication and conflict resolution skills (Babcock et al., 2004; Eckhardt et al., 2013). In other studies, improved communication predicted lower levels of IPV among couples (Gordis, Margolin, & Vickerman, 2005), and partner violent men (Follette & Alexander, 1992; Robertson & Murachver, 2007).

Assessment Protocol and Instruments

Search: Literature searches were conducted using PsycINFO, Google Scholar, and PubMed.
Keywords: *assessment*; *intimate partner violence*; *partner abuse*; *aggression*; *batterer intervention programs*; *risk*; *recidivism*

There are ample reasons why perpetrators should not simply be enrolled in a cursory intake. At a minimum, a proper assessment should determine whether a client is suitable or not suitable for a particular program and whether he or she poses a continuing danger to the victim. Notwithstanding existing state standards that restrict treatment choices, this is a heterogeneous population with various clinical needs, and to the extent that some degree of differential treatment is allowed under state law, that is hardly possible without a thorough assessment. The programs which provided data in the Cannon et al.'s (2016) national survey of BIP reported to allocating on average 90–120 minutes to the intake process, a sufficient amount of time to gather sufficient information to make informed treatment choices. However, no information was provided about the specific assessment protocols used.

Sound assessment protocols—especially those based on client-centered and MI techniques—can help motivate resistant clients and establish early on a strong facilitator–client relationship, which RAC research indicates correlate with reduced rates of recidivistic violence, and are useful in measuring progress and helping clients establish personal treatment goals in even the most rigid, one-size-fits-all formats. For instance, progress toward reducing frequency of physical and nonphysical abuse behaviors can be assisted with administration of either the Revised Conflict Tactics Scales (CTS2) or the original Conflict Tactics Scales in combination with a validated measure of emotional abuse and control, such as the Controlling and Abusive Tactics (CAT) Questionnaire (Hamel, Jones, Dutton, & Graham-Kevan, 2015), the Multidimensional Measure of Emotional Abuse (MMEA; Murphy & Hoover, 2001), or the Measure of Psychologically Abusive Behaviors (MPAB; Follingstad, 2011). Other useful instruments include the Safe at Home questionnaires based on the transtheoretical stages of change theory, which gauges a client's willingness to change and take responsibility for his or her behavior (Sielski, Begun, & Hamel, 2015); the Experiences in Close Relationships Questionnaire-Revised (ECR-R; Fraley, Waller, & Brennan, 2000), useful for identifying

insecure romantic attachment (fear of abandonment or avoidance of intimacy); and the Reasons for Violence Scale, which identifies both expressive and instrumental motives among offenders (G. L. Stuart, Moore, Gordon, Hellmuth, et al., 2006).

IPV risk assessments are used to gather information to determine the likelihood of repeated acts of violence by a romantic partner (Nicholls et al., 2013) and, as such, represent a growing area of interest for existing BIPs. Adequate assessment in this realm is critical, as unlike other violent acts, PA can occur on a near-daily basis and persist for decades (Fals-Stewart, 2003). However, the utility of screening remains undefined. In 2004, the U.S. Preventive Services Task Force (USPSTF) declared that there was insufficient evidence to recommend for or against the use of risk assessment in offender programs (Harris et al., 2001), as the psychometric properties of IPV screening tools were insufficiently studied. Psychometric information is needed to establish the utility of screening and develop informed interventions. For offender programs, the focus of risk assessment follows the principles outlined by Andrews, Bonta, and Hoge (1990) of Risk-Needs-Responsivity (RNR). Thus, the ultimate goal of the various approaches to assessment in BIPs are to identify individuals at risk for repeat violence, as well as any relevant targets for treatment, and then to match treatment strategies to individuals or similar groups (Andrews, Bonta, & Wormith, 2006). Herein, we present a brief summary of recent reviews of IPV risk assessment, along with a list of continuing challenges for clinicians and researchers.

There are multiple approaches to risk assessment for IPV, and each employs a different set of strategies for gathering information. The first is unstructured clinical judgment, which is the most commonly used approach by clinicians (Douglas & Reeves, 2010), and in this approach, the clinician's professional opinion, intuition, and experience are used for gathering information and deciding what information is most related to future violence risk. Because these approaches do not yield a measurable metric of risk, they are impossible to empirically assess (Nicholls et al., 2013). In contrast, actuarial risk assessments examine risk factors using statistical models and previous research to predict the likelihood of future violence. Although this approach produces a total "risk" score that may be helpful in the planning and course of treatment, actuarial methods fail to account for factors with low probability of occurrence that may be meaningful, and many measures still require professional judgment to administer and interpret (Hart & Logan, 2011). In response to the limitations of both actuarial and unstructured clinical judgment methods of risk assessment, the structured professional judgment model emerged. This approach combines the strengths of both approaches by using both statistical prediction and clinician interpretation and is gradually replacing unstructured approaches to risk assessment in BIPs (Douglas & Reeves, 2010). Structured judgment methods use actuarial approaches to yield a measure of predictive accuracy for violent outcomes (Heilbrun, Yasuhara, & Shah, 2010), but ultimately, the clinician has the power to interpret the information and to make practical decisions.

In a recent review of 39 published validation studies of actuarial and structured judgment measures, Nicholls and colleagues (2013) provided a systematic evaluation the state of violence assessment approaches used by a range of assessors (e.g., police,

nurses, social workers, and psychologists). The authors found limited evidence for the superiority of IPV-specific risk assessment over general violence risk assessment measures. This finding may in part reflect study limitations, although it might also suggest a lack of known unique predictors of IPV compared to general violence. Similarly, Hanson, Helmus, and Bourgon (2007) conducted a meta-analysis of IPV risk assessment tools and found comparable levels of predictive accuracy for IPV-specific measures (average weighted *d* of .40, 10 studies) compared to assessments of general violence risk (average weighted *d* of .54, 4 studies), and risk assessments from female partners (average weighted *d* of .36, 5 studies). Although these levels of predictive accuracy are similar, measures often use different information relevant to violence risk. Moreover, measures that are most studied (e.g., the SARA: Kropp, Hart, Webster, & Eaves, 2008; the DA scale: Campbell, 2005) are not used in the ways the authors intended, and it is unclear whether the intended use would lead to changes in reported predictive accuracy. In addition, despite the similar rates across methods of assessment and types of violence, the two measures with the strongest relationship to repeat partner violence were empirically derived actuarial measures (e.g., the DVRAG, $d = .74$; Hilton, Harris, Rice, Houghton, & Eke, 2008; and the VRAG, $d = .65$; Loza, Villeneuve, & Loza-Fanous, 2002), although more studies are needed to adequately compare actuarial and structured judgment approaches.

Overall, the evidence from previous reviews and meta-analyses (Bowen, 2011; Dutton & Kropp, 2000; Hanson et al., 2007; Nicholls et al., 2013) is insufficient to recommend a single IPV screening tool with well-established psychometric properties toward BIPs. This limitation is largely because of the dearth of studies focusing on partner violence compared to other forms of offending (e.g., 88 studies of sexual violence; Hanson & Morton-Bourgon, 2007). Although recent evaluations have demonstrated the utility of many forms of risk assessment above chance prediction, individual measures are limited by improper scoring and training of assessors, reliance on short-term follow-up and retrospective data, information from single informants, as well as a lack of replication studies assessing validity and reliability (Hanson et al., 2007; Nicholls et al., 2013).

Furthermore, study designs are often problematic because of an overreliance on retrospective information, inconsistent definitions of IPV, varied training of assessors (e.g., police, social workers) and follow-up periods, and a lack of studies comparing multiple assessment measures (Nicholls et al., 2013). Overcoming these limitations is essential for both researchers and clinicians, as the lack of a "gold standard" assessment approach leads to inadequate treatment design, matching to an appropriate intervention, and ineffective evaluation of perpetrators. In addition, as J. F. Mills, Kroner, and Morgan (2011) noted, risk assessment for future violence often requires graduate-level training or extensive experience administering, scoring, and interpreting actuarial measures, and BIPs may not be well equipped in this domain. Future studies of risk assessment should also assess the feasibility of extending assessment duties to individuals within the BIP system (e.g., parole officers, social workers, program facilitators) to investigate changes in predictive accuracy. In addition, because

there are several promising measures that have yet to move beyond the pilot stage (see Nicholls et al., 2013 for examples), researchers should focus on the validation of novel risk assessment measures and the comparison of multiple instruments in BIP settings.

In sum, recent studies have demonstrated the value of risk assessment approaches that incorporate empirical measures of risk for future violence, but more work is needed before specific practices can be recommended for BIP risk assessment, management, and treatment planning.

Victim Contact

Search: PsycINFO, Google Scholar, and PubMed using various combinations
Keywords: *victim contact*; *batterers intervention programs*; *intimate partner violence*; *partner abuse*; *assessment*

Contacting victims of IPV is a complicated issue with many levels of impact to consider. Some states allow victim contact, and some do not. Although the CDC considers IPV a national health risk, the proportion of IPV actually reported to police is estimated to range from 2% to 52% (Wolf, Ly, Hobart, & Kernic, 2003). Victims of PA often experience tremendous declines in physical and psychological health following repeated acts of aggression (Lawrence et al., 2012). Additional concerns for BIP organizers are victim characteristics that may prevent reporting as well as fears and past negative experiences with police responders, minimization of the severity of violence, the perceived requirement to end the relationship, and fears of repercussions from the perpetrator (Fanslow & Robinson, 2010; Fugate, Landis, Riordan, Naureckas, & Engel, 2005). Consequently, victim populations require unique consideration when devising plans for assessment and intervention in the legal as well as therapeutic domains. These concerns are often weighted against the value of victim reports for decisions about the effectiveness of treatment and thus continue to represent a challenging aspect of BIPs.

Victim reports on domestic violence inventories remain the basis of court and clinical decision making and program outcome evaluations, as victim safety is often considered the "gold standard" for BIPs (Bennett & Williams, 2001; Heckert & Gondolf, 2000). In addition, there is some evidence that victim reports provide higher rates of recidivism, following BIP treatment compared to police records (Babcock et al., 2004). Despite the clear utility of gathering information from victims, BIPs must thoroughly ensure victim safety before seeking a victim's report on their partner's behavior. Unfortunately, no unitary protocol exists to address ethical issues in the contacting of victims of IPV, and BIPs are left to their own discretion in the choice and circumstance to contact victims (Austin & Dankwort, 1999; Gondolf, 2000).

Although not all states have written guidelines for BIPs (see "Existing State Standards for Perpetrator Programs" section for more information), a recent study found that 93% of state standards require victim contact from the treatment provider during the intake assessment (Maiuro & Eberle, 2008). Furthermore, all standards that

permit victim contact require that the information be de-identified and that care is taken to ensure that the information is not discoverable by the perpetrator. In addition, in 88% of states with standards describing victim contact, the information must be formally documented by letter, telephone call, or personal interview (Maiuro & Eberle, 2008). In these states, the purpose of victim contact is limited to the notification of the perpetrator's progression and compliance in treatment, and most states do not allow victim participation in BIPs beyond the assessment of perpetrator behavior.

The major concern in states that permit or prohibit treatment is the same: ensure victim safety. Some states, such as New York, forbid any victim contact, arguing that the idea of contacting a victim for information itself undermines victim safety. However, no studies to date have explored the impact of contact policies on victim safety. In addition, most states (85%) with standards permitting victim contact enforce "duty to warn" guidelines for treatment providers that necessitate the contact of both victims and police when there is a threat of danger to the victim (Maiuro & Eberle, 2008), with the intention of enhancing safety compared to no-contact policies. Another purpose of victim contact during assessment for BIPs is to develop and revise a safety plan with the victim that accounts for the perpetrator's progress in treatment. Modifications to safety plans are often guided by danger/lethality assessment during intake and throughout treatment (Roehl & Guertin, 2000). Recently, researchers have called for the standardization of risk assessment procedures to better assist in safety planning for victims. However, there is insufficient evidence at present to recommend a single assessment tool for these purposes.

Although the nature of victim contact varies, some states opt to conduct assessment through a victim advocate rather than a BIP official to create a "firewall" of sorts between victim disclosure and program officials. Because perpetrator programs that require victim contact typically include a victim contact statement in the contract for participation that the perpetrator must sign, immediate reporting of victim disclosures to program authorities may place the victim further at risk for violence (Bennett & Williams, 2001). Thus, programs have adopted a victim advocate approach in which the advocate is the sole individual that may contact the victim and agrees only to provide information to the program when it is safe for the victim to do so. To further ensure safety, some programs require that the victim contact the advocate by choice rather than at fixed time points or by the advocate soliciting information (Bennett & Williams, 2001).

Beyond contact for the purpose of risk assessment, recent work has argued for connecting victims to the broader aspects of BIPs. Proposals include greater linkage of victims to resources and increased feelings of safety among victims by enhancing coordinated community responses (Boal & Mankowski, 2014; Klevens, Baker, Shelley, & Ingram, 2008). Such resources may be needed, as a national study found that one-third of women who reported IPV to officials received no formal services or assistance (Fanslow & Robinson, 2010). Recent debates have also appeared in professional journals about whether or not it is appropriate to involve victims in aspects of treatment. Although this concept has demonstrated utility in community samples (e.g., Brannen

& Rubin, 1996; O'Leary, 2001), it is unclear whether or not victim participation would be advisable for perpetrator populations because of potential differences in severity and directionality of abuse. In the future, BIP standards and legal interventions may expand to provide assistive services to victims. Currently, we must work to find the best policies for victims in BIPs to promote safety and prevent violence.

Modality of Treatment

Search: PsycINFO; Google Scholar; organizer's list of references
Keywords: *batterer intervention*; *Duluth*; *cognitive-behavioral*; *couples*; *domestic violence*; *intimate partner violence*

Although evidence for a superior modality of perpetrator programs is lacking, some states in the United States (5%) have gone so far as to explicitly ban the use of individual treatment (e.g., Georgia and Maine; Maiuro & Eberle, 2008). In addition, 68% of states prohibit the use of couples' treatment of any kind either before or concurrent with a primary domestic violence intervention. In the select states that do not explicitly ban couples therapy for domestic violence, standards prohibit any couples-based intervention that advocates for an equal distribution of responsibility for violence or abuse (Maiuro & Eberle, 2008).

Group. The most commonly prescribed interventions for domestic violence occur in a group format, implemented by 97% of BIPs in the United States and Canada (Cannon et al., 2016). While lamenting the rigidity of one-size-fits-all intervention policies, Maiuro, Hagar, Lin, and Olson (2001) argue that there are advantages to group format, such as helping the perpetrator feel understood among peers and overcome not only denial but also feelings of shame and thus motivating him or her to stay in treatment. As already discussed in a previous section, outcome studies on BIPs have focused almost exclusively on the group modality and find this format minimally to moderately successful depending on study design.

Individual Therapy. Because of the diversity of offenders and treatment needs, the modality of one-on-one therapy is a crucial option for intervention. Some offenders, because of extreme social anxiety or posttraumatic stress disorder (PTSD), poor cognitive functioning, serious mental health problems, or personality disorders, are not suitable for group, as acknowledged in several written state standards. Currently, 45% of BIPs offer this modality to domestic violence perpetrators (Cannon et al., 2016). Other offenders present with very minor abuse histories and already possess most of the emotion management and communication skills normally taught in psychoeducational group format and would prefer individual sessions to address broader issues and would feel uncomfortable and stigmatized in a group with "batterers" (Hamel, 2014).

For many perpetrators, the one-on-one format would not be appropriate. One concern that has traditionally been raised is that individual therapy may not hold

offenders as accountable as group. Writing on behalf of the Men Stopping Violence (MSV) program in Atlanta, Georgia, Kaufman (2001) cautions that

> In individual therapy, a client may well focus on his history of being victimized. To do that without having been steeped in how not to victimize others, creates at best confusion and at worst a man who is likely to do what he has done in the past when he was upset—blame and attack his partner. In an interview with a batterer, David Adams quotes a counselor asking the man, "Are you waiting to stop feeling insecure before you stop being violent?" (in Bograd & Yllo, 1988). Dealing with the traumatic effects of having been abused and victimized is important work, but it is not likely to have the immediate effect of stopping a man from acting in controlling and abusive ways. MSV strives to keep the reality and experience of others, not just the batterer, always in the forefront. (p. 1)

Such concerns are, to some extent, valid, but the danger to victims is unlikely to be with the modality per se but rather the therapist's skills set and competence, and whether or not a client acquires early on the necessary emotion management skills with which to stop their abuse, Murphy and Eckhardt (2005) argue that individual treatment can hold perpetrators more accountable in comparison to group treatment, particularly those groups that are too large or led by poorly trained facilitators who are unable to prevent negative role modeling and reinforcement. So far, the only outcome studies to have been published on individual psychotherapy have focused on the effectiveness of MI techniques delivered in the one-on-one format but only for a short number of sessions (Crane & Eckhardt, 2013; Crane, Eckhardt, & Schlauch, 2015; Kistenmacher & Weiss, 2008; Mbilinyi et al., 2011; Murphy, Linehan, Reyner, Musser, & Taft, 2012; Musser, Semiatin, Taft, & Murphy, 2008; Woodin & O'Leary, 2010). (The empirically demonstrated effectiveness of MI is discussed in an upcoming section.) No research has directly compared the benefits and pitfalls of ongoing group versus individual modalities, although Murphy and Eckhardt have conducted such studies and are currently in the process of analyzing the results (personal communication, August 3, 2015).

Couples- and Family-Based Approaches. Although many therapists effectively conduct couples and family therapy with cases involving domestic violence (e.g., Hamel, 2008; Potter-Efron, 2005; Stith, McCollum, & Rosen, 2011), couples- and family-based approaches for reducing domestic violence are used by only 14% of BIPs (Cannon et al., 2016), because, at least in part, of restrictions placed under state standards. Social science research calls into question such restrictions. A longitudinal study in Oregon, for instance, found that even when a male perpetrator is guilty of the crime for which he was arrested, it is likely that in the relationship as a whole his female partner had previously perpetrated an equal, or greater, level of physical and emotional abuse against him (Capaldi et al., 2009). Findings from a large multisite study

also indicate that there is a substantial (40%) chance that any physical assaults after BIP completion will be initiated by the female partner (Gondolf, 1996; Straus, 2014).

The social science literature documents the systemic nature of domestic violence and would seem to suggest that conjoint and family formats should be given greater consideration (MacDonell, 2012; Sturge-Apple, Skibo, & Davies, 2012). Some of the relevant findings include the following:

- Children who have witnessed their parents physically abuse one another are at higher risk than other children for experiencing emotional and conduct disturbance, deterioration in peer and family relations, and poor school performance (Wolak & Finkelhor, 1998); and they incur these problems regardless of the parent's gender (English, Marshall, & Stewart, 2003; Fergusson & Horwood, 1998; Johnston & Roseby, 1997; Mahoney, Donnelly, Boxer, & Lewis, 2003).
- There is a high correlation between perpetration of spousal abuse and child abuse for both genders (Appel & Holden, 1998; Margolin & Gordis, 2003; Straus & Smith, 1990).
- Child witnesses to interparental violence are at greater risk for becoming depressed, engaging in substance abuse, and themselves perpetrating intimate PA as adults (Kaura & Allen, 2004; Langhinrichsen-Rohling, Neidig, & Thorn, 1995; Straus, 1991).
- Family violence is a complex phenomenon characterized by various possible pathways of abuse (Appel & Holden, 1998), often reciprocal (Ullman and Straus, 2003), sometimes initiated by the children (Lynch & Cicchetti, 1998; Sheehan, 1997), with stress a central mediator (Margolin & Gordis, 2003; Salzinger et al., 2003).

Based on a thorough review of the family violence literature, Sturge-Apple et al. (2012) write:

> Family systems theory may also serve as a useful heuristic for integrating the study of partner abuse within a broader family context. According to the principle of holism in family systems theory, the meaning of any perturbation in a specific family relationship or subsystem cannot be fully deciphered without an understanding of the relationship structures, boundaries, power distributions, and communication patterns of the other family subsystems and the whole family unit (Davies & Cicchetti, 2004). Thus, a derivative assumption is that difficulty in the marriage may exert an impact on children's functioning through its association with a broader pattern of boundary maintenance difficulties (i.e., ways of exchanging resources and materials across family members) and structure in the family system. Although espoused in clinical work, consideration of the family system in research on partner abuse and conflict is less prevalent. However, we identified several empirical studies that highlight the utility of family systems considerations. (p. 386)

Outcome research on family therapy for IPV is essentially nonexistent; however, family therapy has consistently been found to be more effective than other modalities in preventing relapse among substance abusers (Stanton & Shadish, 1997), an "acting out" population that shares many personality and behavior characteristics with partner violent individuals (Potter-Efron, 2007).

Researchers have conducted numerous quasi-experimental and experimental investigations that examined different types of conjoint interventions, including interventions based on cognitive-behavioral principles (Brannen & Rubin, 1996; Dunford, 2000; O'Leary, Heyman, & Neidig, 1999); Domestic Violence Focused Couples Treatment (DVFCT; Stith, Rosen, McCollum, & Thomsen, 2004); nonaggression-focused behavioral couple therapy (Simpson, Atkins, Gattis, & Christensen, 2008); brief motivation-focused interventions (Woodin & O'Leary, 2010); and interventions based on Gottman's principles such as communication, conflict management, intimacy/friendship, and creating a shared meaning (Adler-Baeder, Robertson, & Schramm, 2010; Bradley et al., 2011; Bradley & Gottman, 2012; Wray, Hoyt, & Gerstle, 2013). These types of interventions typically occur in a group format and include participation from both individuals involved in the violent relationship. Other research has yielded preliminary evidence that while recidivism is significantly reduced when couples participate in either a single-couple or multiple-couple formats, the effects are greater for the latter (Stith et al., 2004).

Considering the possibility of potential danger to victims as a result of participation in conjoint therapy, researchers recommend that couples-based approaches be used only when certain conditions are satisfied; these include absence of major substance abuse or mental health issues, absence of severe violence, accountability for violence from the perpetrators, and an abuse dynamic that stems from stressors that arise in a partnership as opposed to a desire to dominate or control one's partner (Antunes-Alves & De Stefano, 2014; Johnson & Leone, 2005). A well-formulated screening tool has been developed to adequately assess for this particular type of violence and rule out more severe forms, as conjoint interventions for situational violence (SV) specifically have been shown to be effective (Friend, Bradley, Thatcher, & Gottman, 2011). Researchers have identified that the ameliorative effects of couples-based interventions for domestic violence are even more observable when both individuals in the couple desire to remain in the relationship (Eckhardt, Murphy, Black, & Suhr, 2006).

Differential Treatment

Search: PsycINFO; Google Scholar
Keywords: *individually determined treatment*; *type of violence*; *characteristic of perpetrators*; *substance abuse*; *family only*; *generally violent*; *attachment issues*; *borderline issues*

As mentioned earlier, state BIP standards are generally based on a "one-size-fits-all" approach to BIPs with little concern for the heterogeneity of IPV (Cantos & O'Leary,

2014). They restrict treatment options in several ways, including the overall approach to intervention, program content, and the modality in which treatment is delivered. Power and control models of IPV have dominated the U.S. landscape with 48 states in the United States with such standards (Maiuro & Eberle, 2008), and in those states, 75% of the standards mandate models that use power and control concepts as the major focus of their programs. Overall, BIP facilitators appear conflicted about their state standards. In the recent U.S./Canada survey, 60% indicated they "always" follow them, and the remaining 40%, consisting a sizable minority of providers, said that they adhere to the standards only "sometimes." Furthermore, two-thirds report that they "sometimes," "often," or "always" supplement them. Clearly, there is a recognition among providers who work on the front lines that alternative forms of treatment procedures are needed.

One way to begin to address the possibility that BIPs can have salutary effects would be to consider the vast heterogeneity of clients who engage in acts of aggression against their partners. To call everyone who has engaged in any form of physical aggression such as one slap or one push a "batterer" seems misguided as well as insulting (Corvo & Johnson, 2003) as it lumps men and/or women with low-level forms of aggression with those who have repeatedly pummeled their partners and made them fearful. In ordinary English discourse, a batterer is an individual who hits heavily and with repeated blows (http://www.merriam-webster.com). Among domestic violence professionals, the term refers to someone who combines violence with emotionally abusive and controlling behaviors, whose abuse only gets worse over time and causes high levels of fear in their victims. However, research finds that physically aggressive behavior in representative samples actually gets less frequent across time both in the short term (Morse, 1995; O'Leary et al., 1989) and across the decades (O'Leary & Woodin, 2005). Research suggests that the advantages of the group format (e.g., allows participants to identify with one another and obtain social support) can be offset by iatrogenic effects when, for instance, perpetrators convicted of lesser offenses learn to become more violent and manipulative when placed in a group with more violent individuals with personality disorders (Babcock, Canady, Graham, & Schart, 2007; Pan, Neidig, & O'Leary, 1994).

In their research-based book, *When Men Batter Women*, Jacobson and Gottman (1998) defined a batterer as an individual who has engaged in repeated acts of aggression low-level forms of violence (six episodes of such acts as pushing or slapping), two or more episode of high-level violence such as kicking or hitting with a fist, or at least one episode of potentially lethal violence such as wife beaten up. They further stated that such acts are often accompanied by injury and virtually always associated with fear or even terror on the part of the battered woman. Yet, victim experiences of violence and threat vary considerably. For example, Apsler, Cummins, and Carl's (2002) Massachusetts survey found that about half of the women who had their male partners arrested reported that they were not afraid or minimally afraid of their partner, and half said they were certain or fairly certain that the abuse would not be repeated.

Clearly, not all men arrested for engaging in some form of aggression against their spouse meet the definition of a batterer, and there is very ample evidence that the majority of physical aggression that is engaged in by men and women in randomly selected community samples does not lead to fear or injury of the partner. Moreover, the aggression in community samples is more likely to be reciprocal than unilateral (Langhinrichsen-Rohling, Misra, et al., 2012). Consequently, it seems prudent, humane, and honest to have intervention programs for PA, a term that can be used to describe acts of psychological, physical, and sexual aggression with different options including severity and frequency of the aggression, length of the program, and level of judicial monitoring. Furthermore, it seems prudent to have PA programs available to those who want help to be able to do so without court involvement but rather through some county or state service agency, if the level of aggression is low and not fear generating.

In their paper on correctional principles and domestic violence perpetrator treatment, L. Stewart et al. (2013) write:

> Assuming the level of risk has been assessed, the next empirical question should be how much and what kind of service does the perpetrator need? Contrary to earlier statements that "one hit leads to another" and that violence invariably escalates, there is now adequate research to confirm that some perpetrators are low risk and unlikely to reassault no matter what the intervention is. A Statistics Canada (2006) report found that in a 10-year follow-up of a subset of linked police reports from 1995 to 2004, 81% of perpetrators were reported to police a single time within 10 years. Repeat spousal abusers who were reported 2–4 times accounted for 18% of the group and the so-called chronic group accounted for only 1% of the reports. Two-thirds (64%) of spousal incidents reported to police show no escalation in the severity of the violence, another 21% show a de-escalation; only 15% of subsequent incidents escalated in severity. An extensive National Institute of Justice (NIJ) study that supplemented police reports with victim interviews (Maxwell, Garner, & Fagan, 2001) found that more than half of the men arrested for spousal assault committed no further assaults on the same victim during their period of follow-up that extended for 3 years. They did find that a minority continued to commit assaults despite being arrested, receiving counseling, or being separated from their partners. It is probable that early reports of perpetrators' inevitable escalation in the severity and reoccurrence of DV reflect the experience of a select sample from which the reports were obtained, namely retrospective reports from women in shelters who were victims of persistently violent men (Walker, 2009). (pp. 499–500)

Holtzworth-Munroe and Stuart (1994) proposed the most influential male perpetrator typology to date, a three-group typology, namely, (a) family-only, (b) dysphoric/borderline, and (c) generally violent/antisocial. Posing the lowest risk to victims,

Family-only types perpetrate minor levels of physical, emotional, and sexual abuse toward their intimate partners and are not violent toward others and usually do not have a criminal history. They do not harbor hostile attitudes toward women, and although some may be depressed, they usually do not have a personality disorder. On the other hand, these men do have moderate problems with anger and dependency needs and evidence a preoccupied attachment style. These individuals account for about half of men in BIPs. In comparison, men in the other two categories present a much higher risk. They perpetrate all forms of intimate PA at much higher levels but differ in their use of violence outside the home and criminal history as well as personality and attachment style. Follow-up research indicates, however, that these three categories are not entirely stable, with some men shifting from one category to another over time (Holtzworth-Munroe & Meehan, 2004).

Family-only men are more likely to have some intimate social bonds, to be married, and to be employed, and there is some evidence that individuals who have a stake in conformity (i.e., have something to lose by noncompliance) do better in BIPs. More specifically, the men with a stake in conformity are more likely to complete the BIPs and less likely to reoffend (Cantos & O'Leary, 2014). That is, as Cantos and O'Leary (2014) argued elsewhere, men who are older, are married and living with their partner and children, and are employed are more likely to complete treatment programs and less likely to be rearrested for future intimate violence. Stated similarly, Aldorondo and Mederos (2002) argue that "protective orders, arrests, and BIPs are most inadequate in reducing reabuse among men with weak social and intimate bonds" (p. 16).

Babcock, Miller, and Siard (2003) administered various questionnaires to 52 women enrolled in perpetrator programs to measure their use of physical aggression against their intimate partners, other family members, and individuals outside the home and to determine the context and situations in which their violence occurred as well as their motives for their assaults. They identified two distinct categories, family-only and generally violent, that roughly matched two of the types proposed by Holtzworth-Munroe and Stuart (1994). The women characterized as generally violent differed from the family-only women in several ways, including the much more frequent use of physical violence in an instrumental way and to engage in higher rates of controlling and emotionally abusive behaviors against family members and others. They also reported more trauma symptoms and were more likely to have witnessed physical assaults by their mothers. There was insufficient information to determine how many of the women might have had borderline personality disorder. More recently, however, a study of 567 male and female psychiatric patients (231 with a history of IPV perpetration and 336 without such history) found evidence for all three Holtzworth-Munroe and Stuart's (2014) subtypes among the women as well as the men. Although rates of IPV recidivism were about the same across subtypes for the male sample, the rates for generally violent women were twice those for the family-only type (Walsh et al., 2010).

A limitation of these typologies is that they focus on only one part of the relationship dyad, although Walsh et al. (2010) did note that many of the borderline female

perpetrators in their sample were also IPV victims, as were many of the generally violent men. The now well-known typology first proposed by Michael Johnson was derived from criminal as well as community samples and posits four separate categories based on physical violence, emotional abuse and controlling behaviors, and the extent to which the violence is unilateral or bidirectional (Johnson & Leone, 2005; Kelly & Johnson, 2008). SV is characterized by bidirectional physical violence and low levels of emotional abuse and control. In SV, the physical assaults arise within the context of mutual, escalating conflict. In controlling coercive violence (CCV), also known as *intimate terrorism* or *IT*, one person is violent as well as emotionally abusive and controlling, whereas the term *mutual violent control* is used when both partners fit the CCV profile. CCV has been found to correlate with more deleterious physical injuries and mental health outcomes among victims (Hines & Douglas, 2011; Johnson & Leone, 2005; Laroche, 2005; Prospero, 2008). A fourth category, violent resistance, can be used to describe relationships in which one is both physically abusive and violent and controlling, and the other responds with physical aggression (assumed to be self-defensive, in response to the other).

Large-scale national surveys conducted in the United States and have measured the extent of CCV in the general population (Felson & Outlaw, 2007; Jasinski, Blumenstein, & Morgan, 2014; Laroche, 2005). The latest of these surveys identified 36% of female IPV victims to have experienced CCV compared to 35% of male victims. The typology is not without its limitations. There are, for example, overlaps among the categories (Simpson, Doss, Wheeler, & Christensen, 2007; Winstok, 2012), and as defined by Johnson and Leone (2005), the CCV category does not fully capture the most severe types of repeat, injury-producing violence and sexual assaults that come to mind when one thinks of "terrorism," which is mostly perpetrated by men (Dutton, 2006; Hamel & Russell, 2013; Stark, 2007). Clearly, however, there are important treatment implications for this typology, among them determining the appropriateness of couples or family interventions.

At the very basic level, one could separate perpetrators into groups based on severity of physical aggression against their partners because researchers have found that the frequency and severity of physical aggression are robust predictors of violence continuation (Lorber & O'Leary, 2004). One might also separate perpetrators into groups based on whether they were generally aggressive or only aggressive to their partner. Such grouping is associated with dropout and lack of treatment compliance for the former group especially (Cantos & O'Leary, 2014). Independent investigators have replicated this typology and it has been shown to be both reliable and valid (e.g., Stalans, Yarnold, Seng, Olson, & Repp, 2004). Given such differences that relate to effects of BIPs, it is seen as important to have different interventions for different kinds of offenders. One notable example is a study from Florida, where male domestic violence offenders were assigned to a low-, medium- or high-risk offender group. Of the 18,000 men assigned to 1 of 3 treatment options based on severity of offense and mental health/substance abuse issues, 70% completed their program, a completion rate higher than usual 40%–50% for this population. Although the study did not

assign offenders to a comparison group, the 21% recidivism rates were considerably lower than for men who had previously participated in programs under one-size-fits-all policies (Coulter & VandeWeerd, 2009). Furthermore, CBT interventions with non–domestic violence violent offenders have been found to be more successful when based on an RNR model that, in part, assigns treatment based on level of threat and violent history (Bonta, 1996).

One may separate men into different groups depending on their substance addiction (e.g., alcohol or cocaine). One study found the use of MI techniques to be effective in reducing IPV and alcohol ingestion in college dating partners (Woodin & O'Leary, 2010). Another possibility is to design interventions based on a client's mental health or personality profile. Results from Gondolf's (1996) multisite study of BIP indicated that men with avoidant and dependent traits did about as well in process/psychotherapeutic groups as those with narcissistic and antisocial traits in psychoeducational groups. However, in another well-known study, good treatment outcomes were found for male offenders with dependent personalities in process/psychodynamic groups, and those deemed to have antisocial traits benefited from a CBT model (Saunders, 1996).

Regardless of the manner in which clients may be selected for differential interventions, the fact that there is recognition of several options for such is a positive movement in this field. It is unclear whether such selection will lead to differential treatment outcomes, but at minimum, one could hypothesize that such selection would lead to less dropout as the clients would hopefully feel that their own histories are being taken into account when it came to treatment assignment. The usefulness of typologies has not yet been determined with any degree of scientific certainty (Gondolf, 2012), but they do allow for distinctions to be made on a broader spectrum of characteristics than level or history of violence and suggest the possibility of more nuanced intervention strategies.

There is need for openness to varied theoretical orientations, and some that seem worthy of more extensive evaluation include individualized treatment and MI approaches (Murphy, Meis, & Eckhardt, 2009), couple approaches (Hamel & Nichols, 2006; Salis & O'Leary, in press; Stith et al., 2011), individual approaches followed by couple approaches (Geller, 1992; Salis & O'Leary, in press; Stith et al., 2011), cultural context and family systems approaches (Almeida & Hudak, 2002), and acceptance approaches for community members seeking help for coping with emotional problems and difficult relationship who engaged in two or more acts of physical aggression against their partners (Zarling et al., 2015). The acceptance approach for IPV perpetrators, which emphasizes mindfulness techniques and values-directed goal setting, was compared to the treatment as usual in Iowa, and it was associated with less dropout and lower recidivism rates. At a minimum, the varied approaches discussed in this paragraph all seem likely to make dropout much less than traditional approaches. More importantly, they provide an alternative to a model that has had its time and has failed to deliver desired results.

And with low-level forms of partner aggression, even traditional couple approaches that have no focus on physical aggression at all have shown to be effective (Simpson

et al., 2008). Using an acceptance-based CBT, the researchers showed that the presence of low-level forms of physical aggression had no impact on the positive outcome of therapy. Alternatively stated, couples improved in their relationship satisfaction independent of the presence of any low-level forms of physical aggression.

Working With Female Perpetrators

Search: PsycINFO and Google Scholar
Keywords: *treatment or intervention or therapy*; *intimate partner violence*; *partner aggression*; *female perpetrators*; *batterer intervention*

The lack of consensus regarding the treatment needs of male perpetrators is even more pronounced with females. Women arrested for perpetrating partner aggression have been historically assigned to attend perpetrator programs that in many cases were designed for male offenders (Carney & Buttell, 2004b)—specifically, programs such as Duluth that view partner violence through the prism of sociopolitical theories of patriarchy. Clearly, such programs would not be appropriate for female offenders. However, Duluth and feminist models are the primary treatment models for only 40% of BIPs (Cannon et al., 2016); other programs based on CBT, psychotherapeutic, and other models would, at least in theory, more suitably address the needs of female perpetrators. This brings up some important questions. Are female BIP clients so different from their male counterparts that their treatment success requires distinctly different group formats and curricula? Should female offenders be included in groups with male offenders? The review of 46 meta-analyses of the social science literature by Hyde (2005) found men and women to have far more similarities than differences in terms of cognitive abilities, communication, and social and personality variables. Nevertheless, in most U.S. states, individuals who have been convicted of domestic violence and mandated to a BIP are forbidden from attending mixed-gender groups. However, mixed groups do exist. Although rigorous outcome studies have yet to be conducted comparing recidivism rates for same-gender versus mixed-gender groups, one descriptive report from a BIP in Michigan provides some evidence that clients like this format, and that is safe:

> No offense between any group members occurred during or since program participation. This underscores the lack of "danger" posed to the female participants by their male peers as suggested by the state standards . . . no women presented to any involved party (clinician, probation or other court officer, or other) any sense of threat or intimidation. To the contrary, the rates of completion of female participants indicate their experience of safety within the therapeutic setting. In fact, several of the women had previously begun alternative programs and specifically requested the referring courts to allow them to transfer to our program because they did not feel safe in the female-only educational groups to which they had been referred . . . While the specific partners are not available in the group, opportunity exists to practice new skills and get unique

> gender perspectives. This often occurs as increased empathy accompanying a participant's recognition of self as both perpetrator and victim. While empathy is an important component of the secure base in attachment theory and can likely develop in other contexts, the gender perspectives presented in these group settings provide a secure setting for both men and women to experience and apply it. (Hexham, 2010, pp. 480–481)

Over the years several treatment programs specifically for female perpetrators of IPV have been developed and described in books or peer-reviewed journal articles (Bowen, 2009; Carney & Buttell, 2004b; Damant et al., 2014; Dowd, 2001; Dowd & Leisring, 2008; Hamberger & Potente, 1994; Koonin, Cabarcas, & Geffner, 2002; Larance, 2006; Leisring, Dowd, & Rosenbaum, 2003). Although the development of programs tailored to women and the dissemination of such efforts has been important, unfortunately, little is known about whether treatments for female perpetrators of IPV are effective at reducing IPV.

Outcome Studies. Only a few studies have quantitatively examined treatment outcomes for women in perpetrator programs (Buttell, 2002; Carney & Buttell, 2004a, 2006; Tutty, Babins-Wagner, & Rothery, 2006, 2009; Wray et al., 2013), and there have been no RCTs evaluating court-mandated treatments for female perpetrators of IPV. In a qualitative study, T. Walker (2013) interviewed seven women who had completed the Women and Violence Explored (WAVE) program in the United Kingdom. After the 6-week program, the women who were interviewed indicated that they felt that they had gained the ability to manage negative emotions and to recognize antecedents to violent behavior. The first quantitative study examining treatment outcomes for court-mandated partner aggressive women was conducted by Buttell in 2002 using a pretest–posttest design. He examined moral reasoning and found that it did not significantly improve after completion of a 12-week cognitive-behavioral group program in Alabama.

Carney and Buttell (2004b, 2006) used pretest–posttest designs to examine psychological outcomes for partner aggressive women following a 12-week psychoeducational group program in South Carolina originally designed for men. The program is described as feminist-informed and cognitive-behavioral in orientation. Women who underwent the group treatment showed decreases in their passive–aggressive behavior toward partners, decreases in their controlling behaviors toward partners, and decreases in their propensity for abusiveness (i.e., their likelihood of perpetrating physical violence). Although these results are promising, we do not know whether physical aggression decreased after program completion because physical aggression was not assessed. Also, without a control group, we cannot attribute the changes on psychological variables to group treatment attendance.

Tutty and colleagues (2006, 2009) have evaluated the Responsible Choices for Women Program in Alberta, Canada. The program lasts 14–15 weeks and includes unstructured psychotherapeutic and structured psychoeducational components.

A pretest–posttest design was used, and nonphysical abuse toward one's partner decreased after treatment as well as depression, stress, and self-esteem (Tutty et al., 2006). Although significant improvements were found, it should be noted that the scores remained in the clinical range after treatment. Physical abuse toward partners was assessed on a self-report measure, but no significant decreases were found. Also, none of the 33 women in this initial study were court mandated to treatment. Tutty and her colleagues further evaluated the Responsible Choices for Women Program in 2009. In their follow-up study, 101 of 269 women in the treatment program had been referred to the program from the criminal justice system (i.e., court or probation). Using a pretest–posttest design, they found improvements following treatment in depression, stress, and nonphysical abuse toward partners and scores on measures of these constructs were in the normal range following treatment. Physical and nonphysical victimization by partners also significantly decreased. However, self-reported physical aggression perpetrated against romantic partners by both mandated and nonmandated women *increased* after treatment, albeit not significantly (Tutty et al., 2009).

One quasi-experimental study has examined the outcomes of having both members of mutually violent couples attend gender-specific treatment groups to reduce IPV (Wray et al., 2013). Couples who had been court mandated to treatment participated in separate gender specific groups that were 12 sessions in length (Wray et al., 2013). The program was cognitive-behavioral and focused on relationship skills, emotional awareness, and parenting skills. Women reported reduced physical victimization and fewer injuries from their partners from baseline to treatment completion. However, reductions in perpetration of physical aggression toward partners were found for men but not for women following treatment program. Thus, across studies, there are some promising effects of BIPs for women in terms of psychological variables and reductions in nonphysical forms of abuse. However, there is no evidence that BIPs for court-mandated women effectively reduce their own use of physical violence toward partners.

Studies With Related Populations That Have Reduced Physical Partner Abuse Perpetration by Women. Macy, Rizo, Guo, and Ermentrout (2013) developed and evaluated a treatment program for IPV *victims* who were mothers and who had been mandated to services by either the court system or child protective services. The program is located in North Carolina and called Mothers Overcoming Violence through Education and Empowerment (MOVE). It is a 13-week IPV safety and parenting program. It was offered at no cost to the mothers, and child care, dinner, and transportation were provided. The program is described as using a social cognition framework and empowerment philosophy. Supportive group services were provided for the participants' children as well. The women in the program were victims of IPV and were ineligible if they were deemed primary abusers by program staff in the intake phase. Thus, the MOVE program should be viewed as a program for victims and not as a clear BIP for women. Data were collected before and after treatment and

at a 3-month follow-up, but no control group was used. Physical and psychological victimization and perpetration decreased significantly from baseline to treatment completion. Although we cannot attribute the changes to program attendance without a control group, these results are promising.

Bair-Merritt and colleagues (2010) also have evaluated a program for mothers called the Hawaii Healthy Start Home Visitation Program. This program was designed as a home visitation program for new mothers who were at risk for child maltreatment. The program was 3 years in length and was tested in an RCT. It was found to reduce mothers' physical IPV perpetration and victimization. It was described as containing little IPV content, but it may have reduced abuse by lowering parenting stress, increasing parenting efficacy, and increasing support (Bair-Merritt et al., 2010).

A novel approach to reducing partner violence was evaluated by Zarling et al. (2015) using an RCT. They tested the effects of ACT in a 12-week mixed-gender group compared to a support and discussion control condition. The participants were referred from mental health clinicians and reported perpetrating at least two physically aggressive acts toward their current or former romantic partners within the past 6 months to be eligible for the study. It should be noted that although the groups were mixed in terms of gender, participants' partners did not participate in the treatment. Participants in the ACT group reported reduced perpetration of psychological and physical partner aggression posttreatment and at a 6-month follow-up compared to the control group. This study used a community sample of IPV perpetrators, but replication with court-mandated individuals seems warranted because the results were so beneficial.

Clinical Characteristics of Women Intimate Partner Violence Offenders. As is the case in the general population, women and men arrested for domestic violence and mandated to BIPs report comparable levels of physical abuse perpetration as well as emotional abuse and control. In a sample of dually arrested couples, Feder and Henning (2005) found similar rates of minor and severe physical IPV, as well as injuries. Elmquist et al. (2014) compared male and female BIP clients from programs in California and Rhode Island and reported higher rates of both emotional and physical abuse by the women in comparison to the men. They also found similar motives, with men and women about equally likely to abuse for purposes of retaliation, to express anger, in self-defense, or to dominate and control the partner. In Northern California, one BIP reported more or less equal rates of physical and verbal abuse across gender (Hamel, Ferreira, & Buttell, 2015). Comparable scores have been reported between male and female offenders by other researchers on the Safe at Home instrument, which measures readiness to change (Sielski et al., 2015); on the PAS, a predictor of verbal and physical abuse (Carney & Buttell, 2004a); and on measures of emotional abuse and control (Hamel, Jones, et al., 2015; Kernsmith, 2005). However, it should be noted that when fear has been examined in BIP clients, women report experiencing more fear of their violent partners than do men (Ross, 2012). In fact in

a BIP sample, most women reported experiencing fear of their partner, whereas most men did not (Ross, 2012).

Psychiatric Symptoms. Research examining the characteristics of partner aggressive women who have been court mandated to attend treatment has found that psychopathology among such women is common (Dowd, Leisring, & Rosenbaum, 2005; Henning, Jones, & Holdford, 2003; G. L. Stuart, Moore, Gordon, Ramsey, & Kahler, 2006). Henning and colleagues (2003) found that 33% of 112 female domestic violence offenders had probable Axis I diagnoses. G. L. Stuart, Moore, Gordon, Ramsey, and Kahler (2006) found that 35% of women arrested for perpetrating partner violence met a cutoff for a probable diagnosis of depression. In a sample of partner aggressive women in group anger management treatment, 67% reported a history of depression, and 17% reported having bipolar disorder (Dowd et al., 2005). Posttraumatic stress symptoms as well as alcohol and drug problems are also frequently reported (Dowd et al., 2005; G. L. Stuart, Moore, Gordon, Ramsey, et al., 2006). About a third or more of partner aggressive women in clinical samples have symptoms of posttraumatic stress (Leisring, Dowd, & Rosenbaum, 2005; G. L. Stuart, Moore, Gordon, Ramsey, et al., 2006), and 40%–60% of partner aggressive women may meet criteria for a substance use disorder (Dowd et al., 2005; G. L. Stuart, Moore, Gordon, Ramsey, et al., 2006). In their review of risk factors for partner violence, Capaldi et al. (2012) found that depression and alcohol abuse are significant risk factors for women's perpetration of IPV. Additional research examining whether posttraumatic stress symptoms are a significant risk factor for women's IPV perpetration is needed and warranted because we know female perpetrators often have had traumatic experiences (Dowd et al., 2005; Hamberger, 1997; Leisring et al., 2005; Swan & Snow, 2006).

Victimization Experiences. Like men, most partner aggressive women are in bidirectionally abusive relationships (Leisring et al., 2005; Straus & Gelles, 1990; Swan & Snow, 2002, 2006), and this includes women mandated to BIPs. Results from the Hamel, Ferreira, et al. (2015) Northern California study found:

> The percentage of time BIP participants initiated verbal abuse, as opposed to their partner (i.e., was the first to verbally abuse when there was mutual abuse), had a mean of 42.85 (SD = 25.33). There were slight differences by gender, with males initiating verbal abuse 41.82% (SD = 25.54) of the time, compared to females initiating verbal abuse 46.0% (SD = 24.68) of the time. Percentage of the time the client initiated physical abuse, as opposed to the partner, had a total sample average of 36.17 (SD = 32.39). Again, there were small differences between genders, with males reporting that they instigated physical abuse 34.77% (SD = 32.79) of the time compared to females 40.49% (SD = 31.13). (p. 4)

Regardless of whether or not they initiate abuse in their relationships, women of course incur more severe physical injuries (Lawrence et al., 2012). Many partner

aggressive women have also been physically or sexually abused in childhood (Dowd et al., 2005; Hamberger, 1997; Swan & Snow, 2006) or have witnessed domestic violence as children (Hamberger, 1997). Family-of-origin exposure to abuse and parental partner violence have been found to be significant risk factors for the perpetration of PA (Capaldi et al., 2012). Childhood abuse and adult victimization have been found to be associated with posttraumatic stress symptoms in a clinical sample of partner aggressive women, and these symptoms are associated with more frequent perpetration of physical and psychological partner aggression by women (Leisring et al., 2005). Psychological victimization by one's partner has been found to predict physical IPV perpetration among women in a longitudinal study (Murphy & O'Leary, 1989). Services for partner aggressive women need to attend to women's victimization experiences and should include safety planning for women with abusive partners (Leisring et al., 2003).

Some BIPs for women have been found to reduce psychological problems such as stress and depressive symptoms in women (Tutty et al., 2009), psychological PA perpetrated by women (Carney & Buttell, 2006; Tutty et al., 2006, 2009), and PA victimization in women (Tutty et al., 2009; Wray et al., 2013). However, there is currently no evidence that BIPs reduce physical partner aggression perpetrated by women. Many in the field have suggested that treatment for female perpetrators should address common clinical characteristics including depression, trauma symptoms, and substance abuse (Dowd, 2001; Dowd & Leisring, 2008; G. L. Stuart, Moore, Gordon, Ramsey, et al., 2006). Most BIPs that have been evaluated in the field thus far do not seem to actively target such problems. Participants in the Responsible Choices for Women program reported reductions in depression and stress at the end of treatment, but unfortunately, their physical IPV perpetration rates increased, although not significantly (Tutty et al., 2009).

Summary Regarding Interventions for Female Perpetrators. The most promising avenues for reducing women's perpetration of IPV are programs that have not been designed as BIPs. Women in the MOVE program, developed to assist maternal victims of IPV, reduced their IPV perpetration as evidenced by self-report pretest–posttest data (Macy et al., 2013). Thus, a controlled study of the MOVE program as a BIP is warranted. The MOVE program is offered for free to participants and includes free child care. These characteristics seem particularly appropriate given that many women in treatment for partner violence perpetration are economically disadvantaged (Dowd et al., 2005) and in need of assistance with referrals for child care (Dowd, 2001). Reducing stress and increasing parenting efficacy may have helped mothers in the Hawaii Healthy Start Home Visitation Program to reduce their IPV perpetration (Bair-Merritt et al., 2010). A 3-year home visitation program is unlikely to be feasible as a BIP because of its costly nature, but perhaps, BIPs should include an emphasis on parenting and parental stress. ACT is a novel approach, and the results of the RCT of ACT with a partner violent clinical/community sample were impressive (Zarling et al., 2015). A trial of ACT with court-mandated women would be an

exciting development. At this point in time, there is not enough evidence to recommend standards for the treatment of women arrested for IPV perpetration. However, a focus on safety planning/victimization, acceptance and mindfulness strategies, stress reduction, emotion regulation, and parenting within BIPs for women seem to be promising strategies worthy of further investigation.

Working With Perpetrators in Racial and Ethnic Minority Groups

Search: EBSCOhost Academic Search Complete; Elsevier Freedom Collection; Google Scholar; Sage Complete; Social Work Abstracts; ScienceDirect; Association of Domestic Violence Intervention
Keywords: *intimate partner violence*; *ethnic minorities*; *racial groups*; *culturally-focused intervention*; *culturally-sensitive intervention*; *batterer intervention programs*; *domestic violence*

Over the last couple decades, practitioners and researchers have empirically established that IPV occurs among all racial and ethnic groups. However, there is very little research investigating ways in which BIPs may better address the particular structural, cultural, and contextual issues that lead to IPV in ethnic and racial minority groups. Although some research indicates no difference between racial and ethnic minority groups concerning IPV perpetration (Buttell, Powers, & Wang, 2012; Caetano, Cunradi, Clark, & Schafer, 2000; Field & Caetano, 2004; Lipsky, Caetano, & Roy-Byrne, 2009; Rennison & Planty, 2003), most research on the topic highlights race and ethnicity as indicators of IPV (Caetano, Ramisetty-Mikler, & Field, 2005; Carney & Buttell, 2005, 2006; Melander, Noel, & Tyler, 2010; West, 2012). Culturally focused BIP curricula have received mixed reviews concerning their effectiveness (Gelles, 2001; Gondolf & Williams, 2001; Almeida, Woods, Messineo, & Font, 1998); however, more research should be conducted identifying beneficial cultural factors for integrating into curricula, and more studies should be directed toward the evaluation of these culturally centered programs.

The purpose of this literature review is to (a) investigate the difference in effectiveness of conventional state-mandated BIPs between different racial and ethnic minority groups; (b) investigate the effectiveness of culturally focused BIP curricula on different racial and ethnic minority groups (Black and Latino/Latina); (c) determine the prevalence of IPV among Black, Latino/Latina, and Asian groups; and (d) identify cultural and structural components of particular racial and ethnic groups that could inform the development of culturally focused interventions for Black, Latino/Latina, Asian, and Native American groups. To present a comprehensive overview of the relevant literature, we searched the databases EBSCOhost Academic Search Complete, Elsevier Freedom Collection, Google Scholar, Sage Complete, Social Work Abstracts, ScienceDirect, and the Association of Domestic Violence Intervention Programs website with combinations of keywords such as *intimate partner violence*, *ethnic minorities*, *racial groups*, *culturally focused intervention*, *culturally sensitive intervention*, *batterer intervention programs*, and *domestic violence*. This review identified only four

quantitative studies examining the effectiveness of BIPs between racial and ethnic groups (i.e., Buttell & Carney, 2005, 2006; Gondolf, 2007, 2008). All other researcher consisted of qualitative studies or theoretical articles pertaining to the development of culturally focused BIP curricula for different racial and ethnic groups. The review identified no studies that used an RAC research design.

Prevalence in Minority Groups. African Americans disproportionately represent victims and perpetrators of domestic violence (particularly IPV) in the United States (Walters, Chen, & Breiding, 2013; Williams, Oliver, & Pope, 2008). Furthermore, research also suggests there are vast discrepancies between African American, White, and Hispanic men concerning domestic violence arrests and sentencing (for excellent summaries of this literature, see Lipsky et al., 2009; Shernock & Russell, 2012). Related to BIP completion, studies indicate that African American participants drop out prematurely relative to White participants (Gondolf, 1997; Williams & Becker, 1994). These findings suggest the presence of particular structural issues experienced to varying degrees by different races and ethnicities that lead to the propensity for violence and suggest a need for culturally focused curricula.

Although Latinos have become the largest ethnic minority group in the United States (United States Census Bureau, in press), very little is known about the rates of BIP completion by Latino/Latina perpetrators or culturally focused interventions directed toward the Latino/Latina community. Furthermore, the prevalence of IPV perpetration among Latino/Latina perpetrators of IPV remains vague. Studies suggest that the prevalence of IPV perpetration among Latino/Latina populations is anywhere between 23% and 68% (Hancock & Siu, 2009; Klevens, 2007; Tjaden & Thoennes, 2000; Walters et al., 2013). Researchers indicate that the ambiguity of these results may be related to factors such as immigration status, country of origin, proficiency in English, or perceived trust of institutions (Caetano, Schafer, & Cunradi, 2001; Field & Caetano, 2003). Furthermore, reporting may be low among Latino/Latina groups because IPV is not widely recognized in Latin America and Mexico as a health and social issue resulting in very little accessible support for victims (Aldorondo & Mederos, 2002).

Only qualitative research examines the prevalence of IPV in Asian populations (Chang, Shen, & Takeuchi, 2009; Leung & Cheung, 2008). Chang et al. (2009) reported comparable rates of minor violence perpetration between men (14.7%) and women (19.0%). Furthermore, combined IPV rates of men and women showed that IPV prevalence was highest among Vietnamese and Filipino groups and least prevalent in Chinese and Japanese groups.

Difference in Batterer Intervention Program Effectiveness Between Racial and Ethnic Minority Groups. According to the national survey, recently conducted by Cannon et al. (2016) in the United States and Canada, 20.0% of offenders enrolled in perpetrator programs are African American, 18.0% are Latino, 5% are American Indian or Indigenous, and 3.0% are Asian.

Although researchers have identified disparities between racial and ethnic groups pertaining to the prevalence of IPV and BIP completion, little research has been conducted examining the overall effectiveness of culturally focused interventions. This may be explained by the widespread acceptance and enforcement of state-mandated legislative standards for BIPs (currently, 45 states have legislated governing standards for BIPs), therefore causing the implementation of culturally focused programming to be the exception rather than the rule (Kernsmith & Kernsmith, 2009). The conventional framework for BIPs consists of a feminist-informed, cognitive-behavioral group treatment commonly referred to as the Duluth model. This approach, initially designed for White, lower middle class, male perpetrators, incorporates a patriarchal analysis of male–female relationships (Cannon & Buttell, 2015; Gelles, 2001; Holtzworth-Munroe, 2001), leaving racial and ethnic minority groups as well as the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community ineffectively addressed. As a result of these issues, researchers have pushed for more culturally focused programming (Almeida et al., 1998; Gelles, 2001; Gondolf & Williams, 2001).

Scant research examines the difference in effectiveness of state-mandated BIPs between different racial and ethnic minority groups (Buttell & Carney, 2005, 2006; Buttell & Pike, 2003; Buttell et al., 2011; Walling, Suvak, Howard, Taft, & Murphy, 2012), and the available studies have produced mixed conclusions. In a study of 91 men (57% African American) court ordered to complete a BIP, Buttell and Pike (2003) determined that significant, positive changes occurred at equal rates in both White and African American perpetrators. In contrast, Buttell and Carney (2005) conducted a secondary analysis of 142 state-mandated treatment completers, randomly selected from a larger sample of 733 program participants (38% African American), and determined that the BIP was only slightly effective in improving psychological variables related to IPV. Furthermore, Buttell and Carney concluded that the BIP was equally ineffective for both African American and White participants. In a similar study examining 850 program completers in a court-mandated 26-week BIP (51% African American), Buttell and Carney (2006) discovered similar findings; there was no improvement in psychological variables related to IPV and no significant difference in program outcomes for African American and White participants.

The wide acceptance of state-mandated BIP standards leaves limited space for flexibility and creativity in developing new program curricula. For this reason, there have been few opportunities to investigate the effectiveness of culturally focused programs for different racial and ethnic minority groups (Gondolf, 2007, 2008; Parra-Cardona et al., 2013). In a quasi-experimental study examining the effectiveness of culturally focused counseling with African American men arrested for domestic violence, Gondolf (2007) tested the effectiveness of culturally focused counseling against conventional cognitive-behavioral counseling in racially mixed groups and all–African American groups ($N = 501$). Findings demonstrated no evident benefit from culturally focused or conventional cognitive-behavioral counseling in all–African American groups over racially mixed group counseling. In addition, those clients with higher

racial identification did not experience more effective outcomes from culturally focused counseling.

Gondolf (2008) implemented a classical experimental design to investigate program completion rates of (a) all–African American groups participating in culturally focused counseling, (b) all–African American groups participating in conventional counseling, and (c) racially mixed groups participating in conventional counseling (randomly assigned, $N = 501$). With an overall completion rate of 55%, findings showed that completion rates increased to between 63% and 65% in the conventional all–African American groups and the culturally focused all–African American groups, respectively. In contrast, the completion rate for racially mixed groups was only 40%. Although the specialized intervention did not improve program completion overall, it at least marginally benefited some of the men who highly identified with the African American culture. Because the possible influence of racial identification suggests that diversity within the African American group should be considered in developing effective methods of counseling, Gondolf (2008) concludes these results should refine the argument for culturally focused counseling rather than dismiss it.

Even fewer studies examine the effectiveness of culturally based BIPs for Latino perpetrators Parra-Cardona et al. (2013) conducted a qualitative study of Latino immigrant men ($N = 21$) who participated in a Spanish version of the Duluth model intervention program for men. Program participants consistently indicated that the homogeneous nature of the group allowed for opportunities to discuss values particularly relevant to Latino culture as well as challenges they face as a result of discrimination, exclusion, and immigration status. Although interventions based only on these findings may not be considered evidence-based, the increased participation and satisfaction of Latino offenders in this culturally focused program suggests reason for further investigation into the benefits of culturally based curricula for Latinos. Finally, no research was found regarding the effectiveness of culturally focused interventions for other ethnic minority groups.

Risk Factors and Developing Culturally Focused Approaches by Ethnic Group. In an effort to contribute to the development of culturally relevant BIP curricula for racial and ethnic minority groups, researchers have investigated significant personal, familial, and structural issues specific to IPV perpetrators of different races and ethnicities. Researchers have examined the intersection of socioeconomic conditions and racism and its role in African American male perpetrators' abusive behavior (Ackard, Neumark-Sztainer, & Hannan, 2002; Feldman & Gowen, 1998; Scherzer & Pinderhughes, 2002; West, 2008) as well as other predictors and risk factors of IPV particular to the African American community (Caetano, Cunradi, et al., 2000; Caetano, Field, Ramisetty-Mikler, & Lipsky, 2009; Caetano et al., 2005; Caetano, Schafer, Field, & Nelson, 2002; Clark, Beckett, Wells, & Dungee-Anderson, 1994; Cunradi, 2009; Cunradi, Caetano, Clark, & Schafer, 1999; Cunradi, Caetano, & Schafer, 2002; Field & Caetano, 2003, 2005; Schafer, Caetano, & Cunradi, 2004; West & Rose, 2000). Conwill (2010) posits that the severe realities of internalized and institutional racism

faced by African Americans contribute to low self-esteem and violence. The variables alcohol abuse, use of illegal drugs, unemployment, exposure to community violence, exposure to IPV within family of origin, impoverished neighborhoods, and economic distress (most significant) all appear to be risk factors for African American perpetrators of IPV (Caetano, Cunradi, et al., 2000; Cunradi et al., 2002; Schafer et al., 2004; Williams et al., 2008). In consideration of the development of culturally focused interventions, social conditions and stressors particular to the African American community should be considered and integrated into program curricula.

In an effort to broaden BIP curricula from a conventional feminist framework, Ferreira, Lauve-Moon, and Cannon (2015) employed a nonequivalent, control group design involving a secondary analysis of BIP data ($N = 111$, 43.2% African American). The purpose was to examine the relationship between parenting approaches and IPV while comparing differences in patterns between White and African American perpetrators. A binary logistic regression indicated that number of children and high-risk parenting attitudes were significant predictors of racial group membership, with African American participants having more children and higher risk parenting attitudes. This preliminary evidence suggests that the inclusion of parenting curricula in BIPs could be particularly beneficial for African American perpetrators. Ferreira and Buttell (2016) employed a nonequivalent, control group design comparing treatment completers to dropouts in a secondary analysis of female perpetrators in a 26-week BIP ($N = 485$). Results showed that family-of-origin indicators contributing to an increased propensity for abusiveness were significantly different between racial groups. Although there was no difference in program completion rates between racial groups, understanding the underlying causes (e.g., previous experience of abuse in family of origin) specific to perpetrators of different races and ethnicities could inform the development of more culturally specific interventions (e.g., PTSD treatment).

Hubbert (2011) presents a theoretical framework for examining the intersections of race, IPV, and spirituality for the African American male perpetrator. Several research studies suggest that religion and spirituality serve as a traditional means for coping and transformation in the African American community (Banerjee & Canda, 2009; Frame & Williams, 1996; Martin & Martin, 2002). Accordingly, Hubbert argues that the inclusion of religion and spirituality in BIP curricula would be particularly beneficial to African American perpetrators. Although not definitive in nature, these research findings offer valuable leads in considering the development of culturally focused interventions for African American IPV perpetrators.

Some research has examined the risk factors and cultural indicators of IPV in the Latino/Latina community. However, results should be considered inconclusive at best as the available literature presents varying and often conflicting findings (Caetano, Cunradi, et al., 2000; Caetano et al., 2009; Caetano et al., 2002; Cunradi et al., 1999; Cunradi, Caetano, Clark, & Schafer, 2000; Cunradi et al., 2002; M. R. Duke & Cunradi, 2011; Field & Caetano, 2005; Hancock & Siu, 2009; Kim-Goodwin & Fox, 2009; Sugihara & Warner, 2002). Hancock and Siu (2009) argue for the importance of culturally based interventions for Latino/Latina perpetrators by illustrating that Latino male

perpetrators were not accepting of the conventional model's association between patriarchy and male oppression. In addition, they argue that Latino men become stricter about enforcing traditional gender roles as a coping mechanism during the immigration process and find that immigrant women willingly comply. The researchers conclude by demonstrating relevant issues specific to the Latino/Latina community that could be beneficial in the development of culturally focused program curricula for these groups. These include a focus on oppression and discrimination, traditional cultural expectations pertaining to gender roles, anger management, and individual's cumulative trauma as a precursor of IPV perpetration (Hancock & Siu, 2009). In addition, Cunradi et al. (2000) identified decreasing household income as a predictor of violence. Further empirical research should be conducted to better understand relevant and effective ways in integrating Latino/Latina culture into BIP curricula.

Further research should be directed toward understanding the prevalence of IPV, BIP completion rates, and intervening cultural factors of other ethnic minorities such as Asian and Native American perpetrators. Currently, very few studies examine correlates of IPV in Asian populations (Chang et al., 2009; Leung & Cheung, 2008; Siewert & Flanagan, 2000; Yick, 2000; Yick, Shibusawa, & Agbayani-Siewert, 2000) and even fewer examine Native American populations (Harwell, Moore, & Spence, 2003; Yuan, Koss, Polacca, & Goldman, 2006). Yick and Agbayani-Siewert (2000) determined that those Asian couples that justified violence for particular situations were more likely to be victims or perpetrators of previous violence, and Chang et al. (2009) found that immigrant respondents were less likely to report IPV than U.S. born Asian respondents. Furthermore, Robin, Chester, and Rasmussen (1998) discovered that Asian women were more likely to experience IPV when children were involved. Harwell et al. (2003) employed a telephone survey of Native Americans living near Montana and discovered that risk factors for IPV included childhood trauma, alcohol dependence, being separated or divorced, and greater fluency of tribal language.

Working With Lesbian, Gay, Bisexual, and Transgender Perpetrators

Search: PsycINFO; ScienceDirect; Social Science Collections; Social Work Abstracts; SocINDEX
Keywords: *LGBT*; *batterer intervention programs*; *intimate partner violence*; *domestic violence*; *treatment*

This review covered searches in PsycINFO, ScienceDirect, Social Science Collections, Social Work Abstracts, and SocINDEX using various combinations of the following search terms: *LGBTQ*, *IPV*, *BIP*, *intimate partner violence*, *batterer intervention programs*, *perpetrator*, *homosexual*, *lesbian*, *gay*, *bisexual*, *transgender*, *trans**, *queer*, and *domestic violence*. To date, there are no experimental or quasi-experimental studies on the needs of LGBT offenders (Hamel, 2014). However, clinical reports suggest that culturally sensitive materials and approaches should be used in mixed group settings (i.e., LGBT and heterosexual offenders; Hamel, 2014). To date, no empirical studies have

been conducted on treatment outcomes for LGBT offenders. However, Coleman (2002, 2007) has worked with lesbian offenders, reporting theoretical and clinical recommendations. Given this lack of empirical research, we turn to a discussion of the prevalence rates of PA, risk factors, context, and consequences for the LGBTQ community.

Prevalence Rates of Intimate Partner Violence in Lesbian, Gay, Bisexual, and Transgender Relationships. Because of limited empirical research, it is difficult to determine the rates of IPV in the LGBT community, but recent research estimates IPV is experienced by same-sex partners at similar rates as heterosexual couples (Blosnich & Bossarte, 2009; Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2004; Hellemans, Loeys, Buysse, Dewaele, & Smet, 2015; Mason et al., 2014; Messinger, 2011; Walters et al., 2013). Walters et al. (2013) investigate IPV by sexual orientation according to the CDC's latest NISVS. Sexual orientation was measured by asking whether a respondent considered himself or herself to be "heterosexual or straight, gay or lesbian, or bisexual" (Walters et al., 2013). This question then does not report on IPV in trans* partnerships. This study shows that 43.8% of self-identified lesbians reported to have been physically victimized, stalked, or raped by an intimate partner in their lifetime, 61.1% of bisexual women, and 35.0% of heterosexual women. Or roughly, 714,000 lesbian women, 2 million bisexual women, and 38.3 million heterosexual women have experienced these forms of violence at some point in their lifetime. Almost one-third of lesbian women, half of bisexual women, and a quarter of heterosexual women have experienced at least one form of severe physical violence by an intimate partner. Most women, irrespective of sexual orientation, who experienced rape, physical violence, and/or stalking reported only one perpetrator. Most bisexual women (89.5%) and heterosexual women (98.7%) reported only male perpetrators, and 67.4% of lesbian women reported only female perpetrators.

Approximately 26.0% of gay men, 37.3% of bisexual men, and 29.0% of heterosexual men have experienced rape, physical violence, and/or stalking by an intimate partner during their lifetime (Walters et al., 2013). This translates to 708,000 gay men, 711,000 bisexual men, and 30 million heterosexual men. An estimated one-quarter of all men have experienced shoving, pushing, or slapping by an intimate partner (24.0% of gay men, 27.0% of bisexual men, and 26.3% of heterosexual men). Most men, irrespective of sexual orientation, who experienced rape, physical violence, and/or stalking reported only one perpetrator. Among them, 90.7% of gay men reported only male perpetrators, whereas 78.5% of bisexual men and 99.5% of heterosexual men reported only females as perpetrators.

Female victims who reported three or more perpetrators of sexual violence other than rape were approximately one-third of lesbian women (38.6%), bisexual women (36.4%), and heterosexual women (30.0%). For women who experienced sexual violence other than rape, the perpetrator was only male for 85.2% of lesbian women, 87.5% of bisexual women, and 94.7% of heterosexual women. For male victims, one-third of gay men (33.0%) and one-quarter of heterosexual men reported three or more perpetrators of sexual violence other than rape. Of these men, 78.6% of gay men

and 65.8% of bisexual men reported only male perpetrators of sexual violence other than rape. For a more in-depth analysis of the way types of IPV perpetration vary by sexual orientation, see Walters et al. (2013) and Hamel (2014). Given the newness of this information and the pervasiveness of IPV for LGBT relationships, it seems clear that greater attention should be given to studying IPV in the LGBT populations.

Although tacitly acknowledged as being an important issue, IPV in LGBT relationships has not been thoroughly studied or analyzed, which reveals its actual status as marginalized in research, policy, and treatment of IPV (for a review of empirical studies on IPV in LGBT partnerships, see Bernhard, 2000; Byrne, 1996; Finneran & Stephenson, 2014; Fortunata & Kohn, 2003; Glass et al., 2008; Greene, Fisher, Kuper, Andrews, & Mustanski, 2015; Heintz & Melendez, 2006; Langhinrichsen-Rohling, Misra, et al., 2012; Letellier, 1994; Lie & Gentlewarrior, 1991; Merrill, 1996; Merrill & Wolfe, 2000; Murray, Mobley, Buford, & Searnan-DeJohn, 2006; Oswald, Fonseca, & Hardesty, 2010; Renzetti, 1992; Renzetti & Miley, 1996; Sorenson & Thomas, 2009; Turell, Herrmann, Hollander, & Galletly, 2012; Welles, Corbin, Rich, Reed, & Raj, 2011). As previously noted, the latest NISVS does not ask, and therefore does not collect data on, IPV in trans* identified people's relationships.

To better enable policy and treatment of IPV in LGBT relationships, researchers must first expand their theoretical understanding of the phenomenon. In calling for gender identity and sexual orientation as a means for identifying issues of IPV rather than as an explanation, some scholars seek to cultivate greater awareness of the cultural contexts in which people experience IPV (Baker, Buick, Kim, Moniz, & Nava 2013; Buttell & Starr, 2013; Cannon & Buttell, 2015; Coleman, 2002; Kernsmith, 2006). As Cannon and Buttell (2015) argue this throwaway acknowledgment of IPV as a serious problem in the LGBT community limits the development of effective policy to provide better treatment options to the affected communities. Put simply, if our theoretical framework inhibits our ability to accurately view the problem of IPV in LGBT relations, as scholars who study female perpetrators in heterosexual relationships have found (e.g., A. Duke & Davidson, 2009; Hassouneh & Glass, 2008; Stanley, Bartholomew, Taylor, Oram, & Landolt, 2006), then we will be unable to adequately develop policy that informs better treatment interventions. Similarly, Baker et al. (2013) argue examining same-sex IPV not only informs us of the dynamics and needs of this community but also allows for a critical examination of the ways IPV is framed. Such a maneuver allows for an opening up of the ways we construct and understand factors (motivations, events, outcomes, treatment, etc.) of domestic violence that are most often associated with gender roles and sex-based biological differences. Furthermore, including same-sex relationships in our definition of IPV can serve to mediate the oft-contentious battle between gender or feminist theories and gender-neutral theories (e.g., Baker et al., 2013; Cannon & Buttell, 2015). Analyzing IPV occurring in same-sex relationships, then, is an opportunity to study the characteristics associated with gender as variables instead of gender as an outcome precisely because gender normative behavior and assumptions are already suspended. This latter point is of particular importance, as a strict interpretation of the patriarchal explanation of IPV

would appear to prohibit, by definition, IPV from occurring in lesbian relationships. Consequently, interrogating the IPV occurring in lesbian relationships should allow for a suspension of theory-testing models in favor of an inductive one.

State Standards and Intervention Programs. In their review of 53 state BIP standards collected from 42 states, seven counties, two cities, one island, and one tribal association, Kernsmith and Kernsmith (2009) found that 51% of these standards assumed males were always or often perpetrators of domestic violence against women. The remaining standards assumed a gender-neutral language. These policies for domestic violence intervention services mandated by the state not only overly assume that heterosexual men are batterers but it also assumes that heterosexual women are the victims (Kernsmith & Kernsmith, 2009). These standards express a heteronormative bias—that is, they assume that domestic violence is only perpetuated by heterosexual people, particularly men. Such standards mean that female offenders of female victims will be given the same treatment as a male offender of a male victim, or a male offender of a female victim (Cannon & Buttell, 2015). These standards, then, do not address the particular needs of female perpetrators much less LGBT women perpetrators.

The review by Eckhardt et al. (2013) on the efficacy of BIPs provided no specific data on LGBT partnerships because LGBT was not investigated in the demographics. For example, in their study on leadership, philosophy, and structure of 276 BIPs in 45 states, Price and Rosenbaum (2009) found that although offenders are not a homogeneous group, interventions are based on a "one-size-fits-all" model. Although money constrains possibilities, Price and Rosenbaum (2009) add to a chorus of scholars that advocate for culturally relevant treatment interventions (e.g., Almeida et al., 1998; Burnette, Ferreira, & Buttell, 2015; Cannon & Buttell, 2015; Eckhardt et al., 2013; Ferreira & Buttell 2016; Goldenson, Spidel, Greaves, & Dutton, 2009; Hamel, 2014; Hines & Douglas, 2009; Kernsmith & Kernsmith, 2009; Mauiro & Eberle, 2008). Rather, according to Eckhardt et al.'s (2013) extensive review of research on BIPs, gender reeducation is the predominant focus of treatment interventions because of the presumed notion that IPV is an extension of male dominance and control.

Furthermore, Price and Rosenbaum (2009) found that although same-sex couples were less likely to call the police (Pattavina, Hirschel, Buzawa, Faggiani, & Bentley, 2007; Younglove, Kerr, & Vitello, 2002), and although 78% of BIPs surveyed were willing to provide services to "homosexual batterers," only approximately 1% of clientele openly identified as LGBT. This finding reveals two important issues. First, it indicates the lack of program visibility and ability to guarantee an LGBT person's safety and comfort. Secondly, this finding indicates a lack of outreach to the LGBT community alerting people to possible treatment options (Ford, Slavin, Hilton, & Holt, 2013). Taken together, these findings show it is necessary for state standards to broaden the range of treatment modalities for all IPV perpetrators, especially to encompass the specific needs of the LGBT community, rather than restrict options, as has been generally the case.

Needs of the Community and Treatment. The very limited available literature suggests that treatment providers must be knowledgeable about sexual minority subgroup issues to treat LGBT perpetrators effectively (Coleman, 2002; Istar, 1996). Being knowledgeable of the unique identities, forms of abuse specific to LGBT people (e.g., threatening to reveal a partner's sexual orientation), and impacts of homophobia and heteronormativity experienced by perpetrators may help to successfully locate motivations for IPV in LGBT populations (Coleman, 2002; Istar, 1996). In addition, ameliorating factors particular to experiences of LGBT people may be leveraged. For instance, identifying and confronting a client's defenses against shame and that shame's role in motivating domestic violence may help alleviate such violent behavior (Hockenberry, 1995).

Current state standards, which inform and govern BIPs, and thus, BIPs, may not be able to account for the specific needs of LGBT offenders for several reasons. First, the lack of information collected on trans* identified peoples and their partnerships, as in the case of the NISVS, further marginalizes this group of people while inhibiting researchers ability to describe and analyze the problem of IPV. Secondly, the lack of empirical studies of LGBT offenders means a fundamental lack of understanding about this problem, its triggers, and possible ameliorating factors. Third, given state standards' dependency on the feminist paradigm for explaining IPV as essentially a male expression of power and control fails to account for motivations and treatment interventions to those in LGBT relationships who are not male or do not have access to patriarchy. By focusing exclusively on gender as cause of IPV, scholars miss other psychosocial factors and cultural contexts that contribute to IPV as well as possible factors with ameliorating effects (Baker et al., 2013; Coleman, 1994; West, 2012). Using such a model on which to base state standards fails not only in recognizing the difference of LGBT peoples and their needs but also fails to create BIPs that can perhaps adequately provide meaningful treatment interventions for this population. Given the pervasiveness of IPV in LGBT relationships, in conjunction with the other obstacles LGBT people face (e.g., higher rates of substance abuse, stigmatization, and discrimination; see Klostermann, Kelley, Milletich, & Mignone, 2011; Lewis, Milletich, Kelley, & Woody, 2012), it is necessary and important to treat this social problem. Doing so is but one step in the fight for equality.

Perpetrator Treatment and Practitioner–Client Relationships

Search: Initial steps in conducting the research for this study began with a database search using resources available through the University of Texas at Arlington online library. The database for criminal justice abstracts provided indexing and abstracting for research-oriented serial publications focusing on BIP, human services, social policy, and community development. In addition, Elton Bryson Stephens Company (EBSCO) was used as an access point for information on the fields of social work, social services, social welfare, social policy, and human services related to BIP. The search results included full text, references available, scholarly (peer-reviewed) journals, and abstracts. In addition, the National Institute of Justice (NIJ) website was used as an access point for information on the latest research regarding BIP. Overall, 27 articles

were used for this section of the report. With the use of the keywords and phrases, several online search engines were used to find additional information regarding the topic. Google Scholar, RefSeek, and iSEEK Education provided for a search of scholarly literature including thesis, books, abstracts, article documents, web pages, newspapers, and authoritative resources. All resources provided various bibliographies, and some of the additional literature was identified for use in this study.
Keywords: *batter prevention*; *batter programs*; *criminal justice*; *domestic violence prevention*; *domestic violence policy*; *BIP recidivism*; *BIP intervention*; *facilitator training*; *facilitator education*

The practitioner relationship or alliance is based in part on the work of Bordin (1979), who defined the alliance as including "three features: an agreement on goals, an assignment of task or a series of tasks, and the development of bonds" (p. 253). Although the importance of the practitioner is well documented within the general clinical field of psychotherapy (Wampold, 2015), less is known about the importance of the practitioner relationship with clients who are involuntary or those who are part of a criminal justice response. One exception has come from a small number of studies in the probation criminal justice field (e.g., Kennealy et al., 2012; Paparozzi & Gendreau, 2005; Polaschek, & Ross, 2010) which have argued that while working with offender populations can make relationship building factors difficult, it can be done. Here, there is some recognition that the dual role of support person and control agent can be balanced: firm and authoritative but still fair and respectful. In the following section, we outline an exploratory summary of the literature with respect to practitioner–client relationships and perpetrator treatment.

Facilitator Relationship Importance. Recidivism reduction is an important objective of BIPs. The literature indicates that the facilitator and offender relationship is a key component required for reduced recidivism. For example, Ackerman and Hilsenroth (2003) suggest that relationship may enhance an offender's feelings of being understood and help the offender connect to the process. Connectedness may also afford an opportunity for greater change (Ackerman & Hilsenroth, 2003). Kennealy et al. (2012) posit that quality relationships reduce the risk of recidivism. Roy, Châteauvert, and Richard (2013) indicate that men who participate in IPV treatment emphasize the importance of their relationships with the groups' facilitators. Participants in the Roy et al. study stated that facilitator attitudes, humanism, professionalism, and engagement in nondirective methods were most successful. Especially powerful were group leaders working as facilitators rather than experts (Roy et al., 2013). Of note is leaders serving as facilitator versus authority figures may more easily achieve successful recidivism reduction outcomes. Indeed, research suggests that when facilitators take a more active role through continuous assessment, they can readily identify clients who are not progressing in treatment and can intervene and assess why the client is not improving before the client terminates prematurely (Reese, Norsworthy, & Rowlands, 2009). Furthermore, Dilks, Tasker, and

Wren (2013) suggest that the therapist's strategic effort to develop and maintain a relationship seemed to impact the client's experience in feeling cared about, seeing a way forward, valuing themselves, and building up trust in the therapist. Dilks et al. found that clients were more willing to continue in the program and in turn demonstrated recidivism reduction.

Murphy and Baxter (1997) found that change is best accomplished when the therapist assumes a helping and supportive relationship role. In addition, Andrews, Bonta, and Wormith, (2011) speculated that programs should be concerned with human service delivery rather than relying on the severity of the penalty, suggesting that relationship with the participant is preferable to relationship with the judicial system. With a focus on relationship, it is suggested that treatments could be tailored to the learning style, motivation, abilities, and strengths of the offender (Andrews et al., 2011).

Healey, Smith, and O'Sullivan (1998) suggest that interventions should be tailored to the individual and that psychological factors, risk assessment, and substance abuse history must be considered. Because each individual is unique, programs that are personalized to the individuals tend to be more successful. In other words, interventions that enhance program retention and efficacy should be centered on factors such as differences of poverty, literacy, race, ethnicity, nationality, gender, or sexual orientation (Healey et al., 1998).

Most of the interventions mentioned earlier fall within the purview of professional group facilitators; the profession is guided by standards of ethical practice requiring the development of a professional relationship with the client. Even though they also are responsible to the criminal justice proceeding and the courts, their professional ethical codes indicate facilitators align with the client as opposed to the system. Sullivan, Skovholt, and Jennings (2005) indicate that the therapy relationship is crucial to outcome, can be improved by certain group facilitator contributions, and can be effectively tailored to the individual patient.

Previous outcome studies conducted with correctional populations, as well as individuals in psychotherapy for various mental health disorders, have found a client-centered approach to be significantly correlated with client satisfaction and a reduction in symptoms. A client-centered approach can best be characterized as one in which the client and therapist (or group facilitator) have established a warm and productive alliance and work together in establishing viable, mutually agreed on treatment goals (Eckhardt et al., 2006; Wampold, 2015). Within the past 10 years, a small but growing body of RAC and quasi-experimental outcome research has explored client-centered approaches for domestic violence offender populations. Among the more promising findings have been for psychoeducational programs that incorporate an MI component. MI significantly predicts increased motivation and responsibility taking among partner violent men as well as a stronger client–facilitator alliance and lower recidivism rates (Mbilinyi et al., 2011; Musser et al., 2008; Woodin & O'Leary, 2010). MI techniques also have been significantly correlated with group cohesion, which in turn is correlated with increased motivation as well as reduced rates of recidivism (Alexander, Morris, Tracy, & Frye, 2010; Taft et al., 2003).

Strengths Perspective. Because the overall goal is recidivism reduction, a collaborative facilitator–client relationship seems indicated. One such example is the work of Lee, Uken, and Sebold (2007). Lee and her associates investigated the facilitator role in helping the client develop self-determined goals in predicting recidivism. Their findings concluded that goal specificity and goal agreement between the facilitator and client focused on strengths and solutions predicted lower recidivism (Lee et al., 2007). Their model accounted for 58% of variance in recidivism with the facilitator providing feedback through listening, affirming, restating, expanding, and complimentary responses (Lee et al., 2007). A one-size-fits-all approach intervention is not tenable because of offender population diversity (Healey et al., 1998). Furthermore, Akoensi, Koehler, Lösel, and Humphreys (2013) indicate "treatment effectiveness can be increased when program delivery is tailored to participants learning styles and behavioral profiles" (p. 1218).

Lehmann and Simmons (2009) proposed that facilitators could consider a strengths-based approach to intervention. This would include a facilitator emphasis on "(a) facilitating client directed change, (b) focusing on strengths and resources, not deficits and problems, (c) respecting and being fair to clients regardless of the harm they have inflicted on others, (d) putting values of respect and social justice into action, (e) enabling clients to identify and embrace their unique personal, social, and cultural strengths and abilities, and (f) assisting clients in making changes that are meaningful, significant, and reflect how they want their lives to be" (Lehmann & Simmons, 2009, p. 41). An emphasis on these areas can help the client use their individual strength, values, and interest, thereby changing their poor behavior. The facilitator might build relationships through mutual respect, creating a favorable climate for supporting client-directed change. An excellent instrument for measuring change from a change perspective, rather than pathology, is the Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985).

Divergence. According to Ross, Polaschek, and Ward (2008), therapist and client relationships are strengthened by three factors: (a) agreement on therapy goals, (b) agreement on the task needed to achieve these goals, and (c) agreement on a bond to facilitate this process. This is in contrast to the Duluth model (L. G. Mills, Grauwiler, & Pezold, 2006) which uses a feminist psychoeducational approach to treatment that is a coordinated response by community institutions. This program was advanced from a social work perspective and does not consider the intervention to be therapy (Babcock et al., 2004). In this model, the facilitator leads consciousness-raising exercises that challenge the perpetrator's perceived right to control or dominate his partner (Babcock et al., 2004). This suggests a facilitator role should be that of an authority figure. This has been at the heart of some of the criticism levelled toward the Duluth model.

This does not suggest that facilitators should never use an authoritative approach. Rather, facilitators should be concerned with human service delivery rather than relying on the severity of the penalty (Andrews et al., 2011). With a focus on relationship, cognitive-behavioral treatments should be tailored to the learning style,

motivation, abilities, and strengths of the offender, and that relationship skills include warmth, respect, and collaboration (Andrews et al., 2011).

Required Practitioner Education and Training

Search: http://www.nij.com; http://www.stopvaw.org/batterers_intervention_programs; http://www.battererintervention.org/; https://www.ncjrs.gov/pdffiles1/nij/200331.pdf; http://www.cdc.gov/phlp/docs/menu-batterer.pdf
Keywords: *intimate partner violence*; *batterer intervention programming*; *facilitator education skills*

The purpose of training and education in perpetrator treatment are to provide some minimum standards for knowledge and skills in working with this population. A survey of BIPs across the United States and Canada by Cannon et al. (2016) found that a large proportion of programs require their facilitators to have a bachelor's degree (48%) or a master's (46.9%). On average, facilitators have 8 years of experience conducting perpetrator groups and obtain 30 hours of training annually. Nonetheless, despite this level of education and training, group facilitators are in some respects ill-informed about domestic violence. For instance, 86.5% believe that in abusive relationships, the man initiates the physical violence and 80.3% think that this violence is a means of exercising power and control, whereas only 23.9% believe that women are so motivated. Furthermore, 85% of program directors and facilitators believe that a need to exercise power and control is a "very important" cause of IPV perpetration, when in fact it is primarily a motive for controlling/coercive violence and not for family-only types or for situational couples violence. Remarkably, program directors and facilitators discount the significance of three well-established risk factors: Only 33.3% believe that of having an aggressive personality is very important, 33.6% say that having an abusive partner is very important, and even less (21.6%) regard as very important being unemployed or low income.

A review of domestic violence services throughout the United States, Macy, Giattina, Sangster, Crosby, and Montijo (2009) found that overall, state agencies and coalitions lack agreement on the content and extent of training staff and volunteers should receive to provide effective services. For example, Labriola, Bradley, O'Sullivan, Rempel, and Moore (2010) have said there are three key areas of importance regarding facilitator education and training: (a) obtain a bachelor's degree in a human service–related area or an equivalent combination of college courses and/or applied experience; (b) complete a structured training on the basics of domestic abuse and attend an offenders' education curriculum (should include training on how to conduct a class, the process, what forms are used and group dynamic issues); and (c) all offender program providers must annually complete 12 hours of continuing education training. To date, these recommendations have been largely ignored. Consequently, there are still no national standards for providers at any level from domestic violence advocates to those working in BIPs to clinicians with the required hours of training in most states being at an alarmingly low level (Stover & Lent, 2014).

One critique mentioned is that training programs are often defined as "education" and not "treatment," thereby not requiring a clinical or professional degree. Part of this dilemma has already been pointed out by Gondolf (2012) that in this absence, professionals are therefore guided by their own training and standards with less attention given to guidelines of coalitions or womens' advocates. It can also be argued, of course, that without the broader skill set and commitment to self-analysis and ethical practice that comes with professional training, peer facilitators may be unable to cope with the diversity and complexity of issues associated with domestic violence and therefore more likely when presented with clinical challenges to fall back on overly rigid, ideologically based or simplistic solutions and allow personal biases to affect their work (Corvo & Johnson, 2003; R. Stuart, 2005).

Cooperation among law enforcement, victim advocates, and BIPs is crucial, of course, in the community response to domestic violence. However, if BIPs are to become more effective, then perpetrator interventions must be based on good evidence and accurate information. In this respect, recent studies call into question Gondolf's (2012) assumption that BIPs should be guided in their work primarily by battered women's advocates. In the first study, Hines (2014) examined the fact sheets available on 338 websites of the NCADV, state affiliates, and associated advocacy organizations. Much of the data reported was inaccurate. For instance, about a quarter (26.0%) wrongly stated that IPV is the leading cause of injury to women between the ages of 15 and 44 years in the United States—greater than car accidents, muggings, and rapes combined. The now discredited and misleading assertion that according to the Federal Bureau of Investigation (FBI), a woman is beaten every 15 seconds in the United States was reported by 34.9% of the websites, and 21.3% cited outdated crime surveys claiming 95% of domestic violence victims are women who are abused by male partners. In the second study, a 10-item quiz measuring basic knowledge on IPV was administered online and face-to-face at a major family violence conference by Hamel, Desmarais, Nicholls, Malley-Morrison, and Aaronson (2009) to 410 family court professionals, victim advocates, and college students. Respondents, on average, answered only 2.8 correctly. For example, 43% incorrectly estimated the percentage of male-perpetrated IPV in the general population to be between 85% and 95%, and nearly half (48%) said it is "almost always the man, but sometimes the woman," who perpetrates verbal and emotional abuse and controlling behaviors (it is roughly symmetrical across gender). Among the more interesting findings:

> Post-hoc comparisons showed that family court professionals scored significantly better ($M = 3.11$ out of 10; $SD = 2.01$) than did shelter workers and victim advocates ($M = 1.93$; $SD = 1.00$), ($t(11) = 2.16$, $p < .05$), as did the family law attorneys and family court judges who achieved the best group score ($M = 3.17$; $SD = 2.32$), ($t(84) = 1.96$, $p = .05$). . . . The student group, as predicted, had higher scores on average than did the shelter/victim advocacy group ($M = 2.66$; $SD = 1.65$). (Hamel et al., 2009, p. 43)

Obtaining accurate facts on domestic violence, or finding good evidence-based trainings, is certainly a challenge for practitioners. A source of reliable, up-to-date research on the characteristics, causes, and consequences of domestic violence can be found at http://www.domesticviolenceresearch.org. Every year, numerous family violence conferences are held in the United States, some with solid reputations for disseminating reliable scholarly research—for example, those sponsored by the Institute on Violence, Abuse and Trauma (http://www.ivatcenters.org) and the Family Violence Research Laboratory at the University of New Hampshire (http://cola.unh.edu/frl/conference). The international web-based organization, ADVIP, an acronym for the Association of Domestic Violence Intervention Programs (https://www.domesticviolenceintervention.net/), provides education, training, and networking opportunities for BIPs on multiple continents. Unfortunately, intervention providers are not always aware of such resources or lack the funds to attend a conference in a distant location.

Another startling reminder of the difficulties facing training and education for practitioners are the administrative challenges as well as the lack of information on supervision and consultation for BIP treatment. Opportunities for training and practice advancement begin when upper management and administrators support the "buy in" for training and subsequently provide those opportunities and particularly the financial means to do so. Gondolf (2009) provided one example of how interagency breakdowns contributed to inconsistencies in treatment and referrals for men with mental health issues in one program. Here, the author found administrative absenteeism and turnover; administrative staff gaps, high caseloads, and differing agency priorities were present. Although these problems are similar to issues found in a single agency, it would not be surprising that with lack of funding, limited resources, and competing priorities, this represents a much wider issue at providing education and training within the field.

Likewise, a focus on specific education and training with respect to supervision and consultation is all but absent in the literature (e.g., Werk & Caplan, 1998). Reference to these areas is much more focused on "generic" supervision in the spirit that it can apply at all levels of work with violence. Although there is great value to this thinking, more specific supervision that targets perpetrator treatment cannot be found. Group work with domestic violence offenders is much more than manualization or the implementation of a step-by-step approach. More so, it is about such issues as but not limited to parallel process (Nahmani, Neeman, & Nir, 1991), gender of the group facilitator (Hinote, 2002), worker management of feelings (Champe, Okech, & Rubel, 2013), cultivating self-awareness (Del Moro, 2014), and the mechanics of positive supervision (Bannink, 2015). Supervision and consultation are critical pieces in the management of batter programming and central to responsible and ethical practice.

The path toward greater development of education and training will not occur quickly, because in part of the ongoing politicization of perpetrator intervention. We do, however, take note that there are some areas of change which may provide new avenues for learning and skill development, and identify some current shifts.

One noteworthy shift to the challenges highlighted earlier has been the growth of knowledge in the field of cross-training, the notion of turning to other disciplines in

our field in collaboration with the idea learning how each other integrates and develops concepts, and create knowledge environments. One clear demonstration of this has been the Greenbook Initiative (National Council of Juvenile and Family Court Judges [NCJFCJ], 1999), an effort that grew out of the conversation that domestic violence and child maltreatment were closely linked and that there were many hurdles in responding to this population. In a similar manner, fields such as social work, marriage and family therapy, and psychology have principles of practice that can easily be integrating into cross-training for BIPs, without undermining the importance of safety for survivors nor risking collusion abusive behaviors. Compared to a decade ago, it is now virtually impossible to participate in any professional discussion without acknowledging the importance of partner/child safety. It is also likely that the most experienced practitioners attend workshops and receive continuing education where safety is emphasized at every level of training (Thomas, 2006).

A second trend in training may be seen in the use of online electronic training. This may be one alternative for limited agency resources and for providing facilitator availability to new developments in the field. Although there are many online resources available, to date, only one evaluation of this method has been tested. Hilton and Ham (2015) found that online electronic training of staff on risk assessment was as effective as face-to-face training. One could argue then that BIP training through the Internet could provide availability for skills training.

One final "next step" that speaks to training and education revolves around the practice of training the competent BIP practitioner. At present, training for BIP work revolves around a methodology for practice that is much more content and focused on a manualized protocol. On the other hand, some research does suggest that facilitator intentional self-awareness (Thomas, 2008) as well as actions (what they say and do) in practice can encourage a good working alliance and that this is a critical factor in creating change and positive treatment outcomes (Sullivan et al., 2005). According to J. Stewart (2006), facilitators should have extra-organizational awareness by taking a broad view of their work, have knowledge of change management, and understand various theories. In addition, facilitators should understand organizational development, decision-making processes, systems interaction, how to work with large groups, and group development techniques.

CONCLUSIONS AND IMPLICATIONS FOR TREATMENT STANDARDS

General Recommendations

1. PA can take the form of discrete physical and nonphysical assaults or a pattern of such assaults and often includes a pattern of coercive control of the relationship partner.
2. Perpetrators can be either male or female and vary in personality, social demographics, violence history, and level of threat to the physical and emotional well-being of victims.

3. Victims include child witnesses and the entire family system.
4. Physical PA, sexual abuse, and some forms of emotional abuse are criminal offenses.
5. Holding offenders accountable requires a multisystem response, including effective policing, prosecution, incarceration, judicial monitoring, and/or treatment.
6. Perpetrator treatment is one part of a coordinated community response that includes law enforcement, victim advocates, mental health professionals, and other social service agencies.
7. Regardless of a perpetrator's legal status, treatment should be based on the needs of that individual and the extent to which he or she presents a threat to current and future victims.
8. Treatment should be delivered by providers with substantial and accurate knowledge of PA, including prevalence rates, abuser characteristics, causes and contributing factors, dynamics, and the negative impact on victims and families.
9. Perpetrator treatment plans should be determined through a thorough psychosocial assessment that includes, but is not limited to, known PA risk factors.
10. Treatment should be based on current best practices informed by empirical research on treatment outcome, treatment engagement, and risk factors for PA recidivism. The next section highlights our recommendations based on the best available evidence.

Overall Effectiveness of Batterer Intervention Programs

With respect to treatment effectiveness neither previous (Babcock et al., 2004; Feder & Wilson, 2005) nor more recent meta-analyses/reviews (Arias et al., 2013; Eckhardt et al., 2013) produce convincing evidence that treatment programs for IPV work, especially when considering the more traditional, more widespread, and legally sanctioned Duluth-type program approach emphasizing power and control issues. Quasi-experimental groups are more likely to show change, but as the methodological rigor of a study increases, the likelihood of obtaining significant effects decreases. However, given that the consensus appears to be that there are positive but nonsignificant effects (Arias et al., 2013), it is argued that the question becomes one of not whether the programs work but under what conditions do they work and for whom.

Recommendations

- Given the enormity of the problem and its impact on families and society, as well as strong empirical evidence for the effectiveness of some interventions, it would be premature for policymakers to exclude treatment as an important part of the community response to domestic violence
- There is a strong need for more research on specific moderators of treatment outcome.
- The question becomes one of not whether the programs work but under what conditions do they work and for whom.

Length of Treatment and Length of Group Sessions

A recent survey of BIPs in the United States and Canada, Cannon et al. (2016) found that the average number of sessions in these programs was 30 (SD = 12.12), with a range from 8 to 78 weeks and the modal number of sessions being 26 (N = 178), and that the average length of sessions across programs was 103 minutes (SD = 19.1), with the modal session duration reported as 120 minutes (N = 184). A couple of research reports provide evidence of reduced recidivism in treatments of longer duration; however, a meta-analysis concludes there were greater treatment effects for programs under 16 weeks for both police and partner reports.

Recommendations

- There is not enough evidence to make any recommendations with respect to optimum length of treatment.
- It is important to carry out empirical studies to assess differential outcomes associated with varying treatment length.
- Optimal treatment length may be influenced by various factors, including the duration and intensity of treatment sessions and degree of active engagement in treatment, as well as the needs of particular client populations and the extent to which they are at risk of recidivism.

Number of Participants and Facilitators

To date, there are no experimental studies that have examined the specific effects of different facilitator arrangements (e.g., one male, one female, or a male–female co-facilitator team), facilitator demographics, or group size on recidivism among clients. Surveys of perpetrator program characteristics in the United States and Canada reveal that the average number of clients per intervention was 8 (N = 166), that in most cases, two co-facilitators are responsible for leading these groups with the most common arrangement (approximately one-third of programs) a male–female coleader team. In the absence of empirical data, clinical experience suggests that group cohesion and a strong client–facilitator alliance, so important for group retention and lower levels of posttreatment violence, may not be possible with large groups that impede active engagement of every client and supportive group interactions. There is no clear number to recommend, but certainly groups with more than 8 or 10 participants make it very challenging to promote full and active participation by all group members.

Recommendations

- There is not sufficient evidence to make any conclusive recommendations.
- However, in the absence of empirical data, clinical experience suggests that group cohesion and a strong client–facilitator alliance, so important for group retention and lower levels of posttreatment violence, may not be possible with large groups.

Group Format and Curriculum

A major survey on BIPs revealed that the majority were delivered via group therapy and that they incorporate a wide array of educational components, skills, and techniques into their curricula. Most commonly, curriculum topics include effects of violence on children, identifying power/control tactics, identifying/managing emotions, conflict resolution skills, changing pro-violent/irrational thoughts, consciousness raising about gender roles, general coping skills, general self-awareness, socialization factors, anger/impulse control skills, understanding of childhood experiences, identifying the three-phase battering cycle, assertiveness training, life skills, and meditation and relaxation training. A minority offered grief work, helped clients to identify mutual abuse cycles, or provided them with skills to heal past trauma.

Outcome studies found CBT programs, which incorporate into their curriculum emotion management, communication, and conflict resolutions skills, to be marginally more effective than feminist/power and control models such as Duluth (M. Miller et al., 2013). In addition, specific curriculum topics have been identified that address known risk factors and interventions that address them have some support in the research literature (L. Stewart et al., 2013).

Recommendations

- Known risk factors should provide a basis on which to identify and assess potential educational components.
- The following risk factors were identified along with interventions with demonstrated efficacy: (a) stress, especially from low income and unemployment; (b) having an aggressive personality characterized by a desire to dominate, hostility toward the opposite sex, or attitudes that support violence; (c) poor impulse control; (d) depression; (e) emotional insecurity; (f) alcohol and drug abuse; (g) having witnessed violence between one's parents as a child, or having been abused or neglected by them; and (h) being in an unhappy or high-conflict relationship.

Assessment Protocol and Instruments

The need for a thorough and sound assessment protocol, given the heterogeneity of this population, to identify individuals at risk for repeat violence, as well as any relevant targets for treatment, and then to match treatment strategies to individuals or similar groups (Andrews et al., 2006) is noted. There exist various useful instruments to assess specific areas such as physical violence, emotional abuse, motivation and readiness to change, attachment style, and motivation for violence. However, both early reviews noting the psychometric properties of IPV screening tools were insufficiently studied (USPSTF, 2004), and a more recent systematic evaluation of the state of violence assessment approaches used by a range of assessors (e.g., police, nurses, social workers, and psychologists) concluded that there is limited evidence for

the superiority of IPV-specific risk assessment over general violence risk assessment measures (Nicholls et al., 2013). These reviews suggest that there is much more work needed in this area.

Overall, the evidence from previous reviews and meta-analyses (Bowen, 2011; Dutton & Kropp, 2000; Hanson et al., 2007; Nicholls et al., 2013) is insufficient to recommend a single IPV risk assessment tool with well-established psychometric properties toward BIPs. Future studies of risk assessment should assess both the feasibility of extending assessment duties to individuals within the BIP system (e.g., parole officers, social workers, program facilitators) to investigate changes in predictive accuracy as well as focus on the validation of novel risk assessment measures and the comparison of multiple instruments in BIP settings.

Recommendations

- Perpetrator programs should base treatment on the results of a thorough and sound assessment protocol that
  1. Identifies individuals at risk for repeat violence who pose a continuing threat to victim safety, using a reliable and validated instrument such as the ODARA, SARA, or Propensity for Abusiveness Scale (Dutton, Landolt, Starzomski, & Bodnarchuk, 2001) and, when victim contact is possible, the Danger Assessment or other validated victim questionnaire
  2. Identifies relevant targets for treatment based on an understanding of known risk factors, a thorough psychosocial history, and use of validated questionnaires to determine type, frequency, and severity of abuse perpetrated, impact on the victim and family, motivation to change, and all personality, relationship, and social factors relevant to a client's treatment progress
- Future studies should
  1. Explore how predictive accuracy may vary depending on who is conducting the assessment (e.g., perpetrator program or probation)
  2. Focus on the validation of novel risk assessment measures and the comparison of multiple instruments in BIP settings
  3. Determine the validity and reliability of instruments that measure the quality of therapist–client relationships as well as group dynamics and cohesion, given the importance of these factors in predicting positive treatment outcomes

Victim Contact

Victim contact has been considered to assess treatment effectiveness, to develop and revise a safety plan with the victim that accounts for the perpetrator's progress in treatment, and to connect victims to the broader aspects of BIPs in an effort to provide greater linkage of victims to resources and increased feelings of safety among victims by enhancing coordinated community responses. In spite of the fact that 93% of state standards require victim contact from the treatment provider during

the intake assessment (Maiuro & Eberle, 2008) and that there is some evidence that victim reports provide higher rates of recidivism following BIP treatment compared to police records (Babcock et al., 2004), some states allow contact and some do not because of victim safety concerns. However, no studies to date have explored the impact of contact policies on victim safety. In addition, most states (85%) with standards permitting victim contact enforce "duty to warn" guidelines for treatment providers who necessitate the contact of both victims and police when there is a threat of danger to the victim (Maiuro & Eberle, 2008), with the intention of enhancing safety compared to no-contact policies. Researchers have called for the standardization of risk assessment procedures to better assist in safety planning for victims, but there is insufficient evidence at present to recommend a single assessment tool for risk assessment purposes. Given the safety concerns, programs have adopted a victim advocate approach in which the advocate is the sole individual who may contact the victim and agrees only to provide information to the program when it is safe for the victim to do so. Given the lack of empirical evidence, we must continue to work to find the best policies for victims in BIPs to promote safety and prevent violence.

Recommendations

- Whenever possible, it is important to obtain information on perpetrator recidivism from the victims.
- BIPs must thoroughly ensure victim safety before seeking a victim's report on their partner's behavior.
- There is a need for studies that explore the impact of contact policies on victim safety.
- There is a need for outcome studies that explore the ways BIPs can best work within a coordinated community response to protect victims and lower rates of perpetration.

Modality of Treatment

In spite of the tenuous empirical evidence in its support, the most commonly prescribed interventions for domestic violence occur in a group format, implemented by 97% of BIPs in the United States and Canada (Cannon et al., 2016). Although the need for individual treatment is recognized to address those with special circumstances, such as serious mental health issues, some state standards go as far as prohibiting individual treatment, although 45% of BIPs offer this modality to domestic violence perpetrators (Cannon et al., 2016). In spite of positive evidence forthcoming from numerous quasi-experimental and experimental investigations that examined different types of conjoint interventions, including interventions based on cognitive-behavioral principles (Brannen & Rubin, 1996; Dunford, 2000; O'Leary et al., 1999), DVFCT (Stith et al., 2004), non-aggression-focused behavioral couple therapy (Simpson et al., 2008), brief motivation-focused interventions (Woodin & O'Leary,

2010), and interventions based on Gottman's principles such as communication, conflict management, intimacy/friendship, and creating a shared meaning (Adler-Baeder et al., 2010; Bradley et al., 2011; Bradley & Gottman, 2012; Wray et al., 2013), 68% of states prohibit the use of couples treatment of any kind either before or concurrent with a primary domestic violence intervention. In the select states that do not explicitly ban couples therapy for domestic violence, standards prohibit any couples-based intervention that advocates for an equal distribution of responsibility for violence or abuse (Maiuro & Eberle, 2008) for fear of potential negative impact on the victim.

However, there is no empirical evidence to support this assertion. To the contrary, research has yielded preliminary evidence that while recidivism is significantly reduced when couples participate in either a single-couple or multiple-couple formats, the effects are greater for the latter (Stith et al., 2004). The evidence does not support one approach over another, but there is empirical evidence supporting the use of couple formats especially when used judiciously and monitoring possible negative impact on the victims.

Recommendations

- There is no empirical support for the wholesale prohibition of any particular modality.
- The consensus seems to be that that there are advantages to group format, such as helping the perpetrator feel understood among peers and overcome not only denial but also feelings of shame and thus motivating him or her to stay in treatment.
- The need for individual treatment is recognized to address those with special circumstances, such as serious mental health issues, as well as for individuals who, for other reasons, would not benefit as much from group.
- There is empirical evidence supporting the use of couple formats especially when used judiciously and with monitoring of possible negative impact on the victims.

Differential Treatment

Studies have consistently shown that IPV is not a unitary phenomenon and that instead it varies with respect to the type and severity of violence as well as the characteristic of the perpetrators. Given this heterogeneity, and that not all perpetrators can be classified as batterers, it is proposed that it seems prudent, humane, and honest to have intervention programs for intimate partner aggression, with different options including type of intervention, length of the program, and level of judicial monitoring. It is further argued that given that there is no clear evidence that traditional BIPs with a Duluth-based model are effective, continuing to mandate men to attend such programs presents as a questionable practice and that it is time to explore different alternatives. There is evidence to support placement of

men in different intervention groups based on the severity and generality of the violence, the presence or absence of substance abuse, mental illness, or personality type. Although most states have a mandate with respect to the one-size-fits-all treatment approach, there have been some positive attempts providing interventions responsive to the aforementioned heterogeneity which have produced differential outcomes as hypothesized (Cantos & O'Leary, 2014; Cavanaugh, Solomon, & Gelles, 2011; Fruzzetti & Levensky, 2000; Kliem, Kröger, & Kosfelder, 2010; Tollefson et al., 2009).

There is need for openness to varied theoretical orientations, and some that seem worthy of more extensive evaluation include individualized treatment and MI approaches (Murphy et al., 2009), couple approaches (Hamel & Nichols, 2006; Salis & O'Leary, in press; Stith et al., 2011), individual approaches followed by couple approaches (Geller, 1992; Salis & O'Leary, in press; Stith et al., 2011), cultural context and family systems approaches (Almeida & Hudak, 2002), and acceptance and commitment-based approaches (Zarling et al., 2015). What follows are recommendations, some of which are quite tentative but based on the review of the literature and what we know about characteristics of perpetrators and responses to treatment. Additional research will be needed to determine what specific approach might work with what population. Citations have been included referring the reader to articles providing empirical evidence for the recommended intervention. These treatment recommendations are discussed further in Cantos and O'Leary (2014).

Recommendations

Step 1. Determine the type of violence (Kelly & Johnson, 2008).

- Male perpetrated versus female perpetrated
- Self-defense
- Mutual combat
- Controlling/coercive violent (IT)

Step 2. Determine characteristics of perpetrators.

- Generally violent versus family-only (Cantos, Goldstein, Brenner, O'Leary, & Verborg, 2015)
- Borderline personality characteristics (generalized affect regulation problems) (Holtzworth-Munroe & Stuart, 1994)
- Attachment difficulties (relationship specific affect regulation problems; Dutton & Corvo, 2006)
- Impulse/anger control difficulties (Gondolf, 2000)
- Power and control motivation
- History of substantial head injury (Farrer, Frost, & Hedges, 2012; Howard, 2012)

Step 3. Determine presence of alcohol or substance abuse, and if present, refer to treatment prior to proceeding with IPV treatment.

Step 4. Make treatment decision based on the results of the assessment.

- If abuse is unilateral, refer to intimate partner perpetrator group for further evaluation.
- If controlling/coercive violence (intimate terrorism), refer to power and control group plus close monitoring by probation.
- If mutual combat, refer to couples treatment of IPV (McCollum & Stith, 2008; Simpson et al., 2008)
- If substantial head injury, refer to head injury coping skills group
- If unilateral generally violent
  - ✓ Casework
  - ✓ Help with employment and income, basic needs
  - ✓ Impulse control/anger control skills
  - ✓ Intensive probation monitoring
  - ✓ MI (Scott, King, McGinn, & Hosseini, 2011)
- If family-only
  - ✓ Traditional social learning approach
  - ✓ Discussions on the deleterious consequences of the use of violence in intimate relationships
  - ✓ Anger control skills
  - ✓ Effective communication skills
  - ✓ Use of egalitarian conflict resolution skills
  - ✓ Effective assertion skills
  - ✓ Appropriate expression of feelings
- If unilateral family-only with insecure attachment
  - ✓ Address history of affective relationships.
  - ✓ Address family history, that is, relationship with parents.
  - ✓ Address history of loss within intimate relationships.
  - ✓ Address insecure attachment or avoidant attachment issues.
- If family-only with borderline tendencies (Cavanaugh et al., 2011; Fruzzetti & Levensky, 2000; Kliem et al., 2010; Tollefson & Phillips, 2015; Tollefson et al., 2009):
  - ✓ Dialectical behavior therapy
  - ✓ Mindfulness
  - ✓ Affect regulation skills

Working With Female Perpetrators

The appropriateness of referring women arrested for perpetrating partner aggression to attend perpetrator intervention programs that in many cases were designed for male offenders (Carney & Buttell, 2004b) has been questioned as well as whether they should be seen in same-gender or mixed-gender groups. Existing evidence does not provide evidence for any contraindication for mixed-gender groups. Only a few studies have quantitatively examined treatment outcomes for women in BIPs (Buttell,

2002; Carney & Buttell, 2004a, 2006; Tutty et al., 2006, 2009; Wray et al., 2013), and there have been no RCTs evaluating court-mandated treatments for female perpetrators of IPV. Across studies, there are some promising effects of BIPs for women in terms of psychological variables and reductions in nonphysical forms of abuse. However, we have no evidence that BIPs for court-mandated women effectively reduce their own use of physical violence toward partners. The only evidence for reduction of physical perpetration of IPV comes from interventions addressing at risk parenting with women referred for parenting issues. ACT has been shown to effectively reduce aggression perpetrated by women referred from mental health clinicians.

Available studies support the similarity of aggression by women to that of men with respect to the frequency and severity as well as the reasons for aggressing. Research examining the characteristics of partner aggressive women who have been court mandated to attend treatment has found that psychopathology, in the form of depression, PTSD, and borderline personality, among such women is common (Dowd et al., 2005; Henning et al., 2003; G. L. Stuart, Moore, Gordon, Ramsey, et al., 2006). Like men, most partner aggressive women are in bidirectionally abusive relationships (Leisring et al., 2005; Straus & Gelles, 1990; Swan & Snow, 2002, 2006). Women and men initiate both verbal and physical abuse at similar rates (Hamel, Ferreira, et al., 2015). However, women incur more severe physical injuries from IPV compared to men (Lawrence et al., 2012). Many partner aggressive women have also been physically or sexually abused in childhood (Dowd et al., 2005; Hamberger, 1997; Swan & Snow, 2006) or have witnessed domestic violence as children (Hamberger, 1997). It is thus recommended that services for partner aggressive women need to attend to women's victimization experiences.

In sum, although there are some indications that the treatment needs of female domestic violence offenders differ in some respects from those of their male counterparts, the similarities outweigh the differences, and the preponderance of the research evidence therefore does not support a need for entirely different standards for these two populations.

Recommendations

- Need to develop empirically determined interventions
- Important to address
  - ✓ Contextual variables such as parenting issues
  - ✓ Victimization experiences, including child abuse and victimization by adult partners
  - ✓ Psychopathology, in the form of depression, PTSD, substance abuse disorders, and borderline personality
- Given the similarities across gender with respect to risk factors, physical and psychological PA rates of perpetration, and motives, as well as preliminary evidence for the viability of mixed-gender groups, the use of mixed-gender or same-gender formats should be decided by an assessment of each client's needs and preferences.

Working With Perpetrators in Racial and Ethnic Minority Groups

Very little research has been carried out addressing effectiveness of either standard BIP interventions or culturally focused BIPs with African Americans, Hispanics, or Asians. With respect to African American perpetrators, the conclusion from the limited research that is available seems to be that traditional BIPs are just as ineffective for all races and that culturally focused interventions may be important for those perpetrators with higher racial identification. Given that the variables alcohol abuse, use of illegal drugs, unemployment, exposure to community violence, exposure to IPV within family of origin, impoverished neighborhoods, and economic distress (most significant) all appear to be risk factors for African American perpetrators of IPV (Caetano, Cunradi, et al., 2000; Cunradi et al., 2002; Schafer et al., 2004; Williams et al., 2008), the consensus seems to be that in culturally focused interventions, social conditions and stressors particular to the African American community should be considered and integrated into program curricula as well as religion and spirituality. Increased participation and satisfaction of Latino offenders in a culturally focused program suggests reason for further investigation into the benefits of culturally based curricula for Latinos. Several studies have addressed risk factors and cultural indicators of IPV in the Latino/Latina community; however, results should be considered inconclusive at best as the available literature presents varying and often conflicting findings (Caetano, Cunradi, et al., 2000; Caetano et al., 2009; Caetano et al., 2002; Cunradi et al., 1999; Cunradi et al., 2000; Cunradi et al., 2002; M. R. Duke & Cunradi, 2011; Field & Caetano, 2005; Hancock & Siu, 2009; Kim-Goodwin & Fox, 2009; Sugihara & Warner, 2002). It has been argued that culturally based interventions are important for Latinos because Latino male perpetrators were not accepting of the conventional model's association between patriarchy and male oppression and that enforcement of traditional gender roles is magnified as a coping mechanism during the immigration process. Much less is known about Asians and Native Americans.

Recommendations

- Culturally focused interventions may be important for African Americans with higher racial identification.
- There is a consensus that in culturally focused interventions, social conditions and stressors particular to ethnic minority communities should be considered and integrated into program curricula as well as religion and spirituality.
- Culturally focused interventions appear important for Latinos especially for those who have experienced immigration.
- There is a need to understand more about IPV in Asian and Native American communities to support recommendations about culturally focused interventions.

Working with Lesbian, Gay, Bisexual, and Transgender Perpetrators

There is very limited information available on IPV in LGBT offenders. It is argued that conceptualization of IPV in state standards as an expression of patriarchy through

men's use of violence to dominate and control their female intimate partners has preempted the study of IPV in LGBT populations. To date, no empirical studies have been conducted on treatment outcomes for LGBT offenders. IPV in LGBT relationships has not been thoroughly studied or analyzed, which reveals its actual status as marginalized in research, policy, and treatment of IPV in spite of recent research estimates stating IPV is experienced by same-sex partners at similar or slightly higher rates as heterosexual couples. This lack of attention is even more acute in "trans" identified people's relationships because the latest NISVS does not even ask about this population. The lack of empirical studies of LGBT offenders means a fundamental lack of understanding about this problem, its triggers, and possible ameliorating factors. The very limited available literature suggests that treatment providers must be knowledgeable about sexual minority subgroup issues to treat LGBT clients effectively (Coleman, 2002; Istar, 1996) such as being knowledgeable of the unique identities, forms of abuse specific to LGBT people (e.g., threatening to reveal a partner's sexual orientation), and impacts of homophobia and heteronormativity.

Recommendations

- Substantially more data should be collected on the characteristics and needs of LGBT populations (especially trans).
- Empirical research on treatment approaches for LGBT offenders also needs to be carried out.
- Alternative theoretical models in addition to the feminist paradigm should be created to better understand and frame the problem of IPV in LGBT communities.
- BIPs ought to develop and use culturally relevant curricula in their treatment of LGBT offenders such as addressing forms of abuses specific to LGBT people and impacts of homophobia and heteronormativity.

Perpetrator Treatment and Practitioner–Client Relationships

A small number of studies in the probation criminal justice field (e.g., Kennealy et al., 2012; Paparozzi, & Gendreau, 2005; Polaschek & Ross, 2010) support the notion that the dual role of support person and control agent can be balanced: firm and authoritative but still fair and respectful. The IPV literature indicates that the facilitator and offender relationship is a key component required for reduced recidivism, and when facilitators take a more active role through continuous assessment, they can readily identify clients who are not progressing in treatment and can intervene and assess why the client is not improving before the client terminates prematurely (Reese et al., 2009). Facilitative and supportive relationship roles, goal specificity, and goal agreement between the facilitator and client focused on strengths and solutions have been shown to facilitate change, to impact the client's experience in feeling cared about, seeing a way forward, valuing oneself, and building up trust, willingness to continue in the program and demonstrated recidivism reduction.

Among the more promising findings have been for psychoeducational programs that incorporate an MI component. MI significantly predicts increased motivation and responsibility taking among partner violent men as well as a stronger client–facilitator alliance and lower recidivism rates (Mbilinyi et al., 2011; Musser et al., 2008; Woodin & O'Leary, 2010). MI techniques also have been significantly correlated with group cohesion, which in turn is correlated with increased motivation as well as reduced rates of recidivism (Alexander et al., 2010; Taft et al., 2003).

Recommendations

- It is important for facilitators to develop a client-centered approach.
- Facilitators should take an active role in providing effective treatment based on client needs through continuous assessment.
- Facilitators should adopt facilitative and supportive relationship roles.
- Facilitators should help clients develop specific change goals that are agreeable to both the facilitator and client; change goals should focus on strengths and solutions. MI is likely to be very helpful in these efforts.

Required Group Facilitator Education and Training

A recent survey national survey of BIPs provided evidence that a large majority of facilitators (about 90%) have at least a bachelor's degree; that on average, they have 8 years of experience conducting perpetrator groups and obtain 30 hours of training annually; and that in some respects are ill-informed about domestic violence. There are still no national standards for providers at any level from domestic violence advocates to those working in BIPs and to clinicians with the required hours of training in most states being at an alarmingly low level. Training programs are often defined as "education" and not "treatment," thereby not requiring a clinical or professional degree. It is proposed that if BIPs are to become more effective, then perpetrator interventions must be based on good evidence and accurate information. Recent studies call into question Gondolf's (2012) assumption that BIPs should be guided in their work by battered women's advocates since a review of the fact sheets available on 338 websites of the NCADV, state affiliates, and associated advocacy organizations revealed that much of the data reported was inaccurate (Hines, 2014), and a study measuring basic knowledge on IPV, administered online and face-to-face at a major family violence conference to 410 family court professionals, victim advocates, and college students revealed that respondents answered less than a third of the items correctly (Hamel et al., 2009). Obtaining accurate facts on domestic violence, or finding good evidence-based trainings, is certainly a challenge for practitioners.

There is also a lack of information on supervision and consultation for BIP treatment. A focus on specific education and training with respect to supervision and consultation is all but absent in the literature in spite of the fact that supervision and consultation are critical pieces in the management of batterer programming and central to responsible and ethical practice. The growth in the field of cross-training, the notion of turning to other disciplines in the field in collaboration with

the idea of learning how each other integrates and develops concepts and creates knowledge environments as well as the use of online training are proposed as possible partial solutions to address the knowledge gaps and lack of educational resources in the field.

Recommendations

- Facilitators should be licensed mental health professionals or have at a minimum a bachelor's degree in psychology or related field and be under the direct supervision of a mental health professional.
- Before working with perpetrators, facilitators should first obtain a minimum 40 hours of classroom training, including
  - ✓ 16 hours on basic IPV knowledge, including empirical information on types and prevalence rates of IPV, contextual factors, motivation, relational dynamics, risk factors, and impact on victims and families
  - ✓ 4 hours on the characteristics and efficacy of perpetrator intervention, including BIPs
  - ✓ 4 hours on the role of BIPs in the community-coordinated response to domestic violence
  - ✓ 8 hours on assessment and treatment planning
  - ✓ 8 hours on conducting treatment in the psychoeducational group format
- Facilitators should be familiar with the heterogeneity of both IPV and characteristics of perpetrators and have exposure to different models accounting for the development and maintenance of IPV.
- Facilitators should be trained in all relevant evidence-based assessment and treatment models and approaches.
- Practitioners who work with perpetrators within the modalities of individual, couples, and family therapy should obtain a minimum of 16 additional classroom training hours in those modalities and be licensed mental health professional or registered interns under supervision by a mental health professional.
- Others with a minimum bachelor's degree in psychology or related field and under the direct supervision of a mental health professional may work within a group format, provided that it is a psychoeducational rather than a therapeutic or process group.
- Training materials/information should be based on the most reliable and current scholarly research, such as the PASK literature reviews (http://www.domesticviolencerearch.org), or other resources that may become available in the future.
- Trainees should be expected to demonstrate mastery of relevant training material—for example, as demonstrated through completion of a test of this knowledge.
- Following classroom training, practitioners should complete hands-on training as they provide therapy or conduct groups with IPV perpetrators for a time period that is sufficient to develop skills for independent practice, typically a

minimum of 1 year, or the time period required to do 52 client sessions, under the supervision of a certified IPV practitioner:

- ✓ 1 hour weekly supervision or 2 hours if practitioner is working with three or more therapy clients or groups
- ✓ Supervision of nontherapists to take place during group sessions/or observed through one-way mirror for 24 weeks
- ✓ Supervision of therapist interns must take place in group sessions/or observed through one-way mirror for 12 weeks.
- ✓ Supervision of licensed therapists can be done outside the therapy office/group room.

- Requirements for trainers
  - ✓ Be a licensed mental health professional with at least master's degree in the social sciences
  - ✓ Have worked in the field of IPV for a minimum of 10 years, with at least 4 years of direct experience working with IPV perpetrators
  - ✓ Be a certified IPV practitioner, having successfully completed the 40-hour minimum classroom training and the hands-on 52-week supervised training

Limitations and Suggestions for Future Research

This integrative review highlights numerous areas in need of experimental studies to examine the potential impact of variations in program structure and approach. Examples of structural program considerations include variations in the length of treatment, duration of sessions, format (e.g., group vs. individual), facilitator education and training, and facilitator arrangements (e.g., single vs. dual facilitators; same vs. opposite gender pairs). There is an even longer list of variations in program philosophies and practices in need of further research. Examples include the use of supportive versus confrontational approaches, skills-oriented versus process-oriented groups, and many potential variations in the focus and content of change, such as mindfulness, emotion regulation, attachment anxiety, anger management, assertiveness, communication skills, and so forth. Additional considerations include the hypothesis that different subgroups of IPV offenders will respond more favorably to different intervention approaches. Finally, pressing questions remain about the nature, timing, and need for treatment to address a myriad of comorbid difficulties that include alcohol abuse, other drug abuse, depression, unemployment, personality dysfunction, and posttraumatic reactions.

In addition to the need for a greater evidence base examining the impact of different program structures and approaches, the review identifies significant gaps in research on diverse samples and populations. Taking gender as one example, none of the 30 controlled studies of IPV perpetrator interventions identified in a recent state of knowledge review had any female perpetrators in their samples. LGBTQ populations are likewise seriously underrepresented in existing IPV intervention research. The review also reveals a substantial need for research on program adaptations and

culturally focused interventions within the United States for Native Americans, African Americans, and Hispanic Americans as well as a variety of immigrant populations. Context will be crucially important in these efforts, including variations in socioeconomic conditions and in the challenges faced by urban, suburban, and rural populations.

Unfortunately, funding for IPV intervention research appears to be shrinking, and enthusiasm for this area of research among policymakers and other key stakeholders may be waning. In light of these considerations, it is crucially important to prioritize specific research questions and approaches from among the myriad of possible research questions highlighted in this review. Toward that end, the following suggestions highlight several key areas for empirical research that may guide the further development of best practices and practice guidelines for IPV intervention.

Models That Integrate Risk Assessment and Risk Management With Intimate Partner Violence Intervention. As noted earlier in the review, virtually all efficacy research on IPV interventions has relied on "one-size-fits-all" models that pay little or no attention to individual risk patterns and needs (Eckhardt et al., 2013). In contrast, Andrews and Bonta's (2010) RNR model is both a highly influential and empirically sound approach to psychosocial intervention with criminal offenders. This model maintains that successful interventions must be responsive to the specific risk profile and criminogenic needs of the individual offender. An extensive body of research supports the efficacy of intervention approaches that rely on RNR principles for other populations of criminal offenders (e.g., Andrews & Bonta, 2010). Nevertheless, no studies to date have examined the efficacy of IPV interventions that are responsive to the specific risk profiles of IPV offenders despite the availability of forensic tools, such as the SARA (Kropp et al., 2008), which was developed to help guide risk management and intervention planning for this population.

One notable example is the Colorado standards for IPV intervention, which require IPV intervention staff to work together on a multidisciplinary team with victim advocates and legal system representatives. The multidisciplinary team assesses the presence of 14 IPV risk factors; uses the risk data to place each offender into low-, medium-, or high-risk categories; and develops an individualized service plan for each case. Differential intervention is provided, with low-risk cases receiving standard weekly group intervention and high-risk cases receiving a minimum of two clinical contacts per week (Gover, Richards, & Tomsich, 2015). An initial process evaluation identified some implementation challenges, including the fact that very few cases (about 10%) were categorized as low risk, and the fact that high-risk cases were very unlikely to successfully complete IPV intervention (Gover et al., 2015). Despite these challenges, the Colorado approach represents a unique effort to coordinate IPV intervention using an RNR framework designed to provide monitoring and intervention services that are matched to client risk profiles.

In light of the extensive body of research on other populations of criminal offenders, and the extensive literature (much of which is reviewed earlier) on risk factors

for IPV recidivism, it should be a high priority to determine whether approaches that tailor the intensity and focus of IPV intervention to the specific risk profiles of individual offenders can enhance safety and violence reduction relative to standard approaches currently in widespread use.

Does One Size Fit Most? Interventions for Low-Risk Offenders. As noted previously in the section on differential treatment (pp. 387–393), there is some research evidence suggesting that some treatment approaches may be more effective than others, depending on the characteristics of the perpetrator and type of violence. However, it was also acknowledged that the treatment guidelines are tentative and that much more research is needed. Furthermore, this review has found that the majority of participants in IPV treatment (typically 60%–70%) do not generate victim–partner reports of recidivist violence within a 1- to 2-year follow-up period. The experience of being detected as an IPV perpetrator, subject to legal sanctions, monitored, and exposed to counseling appears to be a sufficient intervention to bring about violence cessation for most IPV offenders. These findings suggest that a "one-size-fits-most" approach involving a coordinated community response has significant merit. Furthermore, correlational evidence indicates that exposure to more elements of the coordinated community response system (including arrest, effective prosecution, probation monitoring, and IPV counseling) is associated with lower IPV recidivism (Murphy, Musser, & Maton, 1998). These findings may be useful for public policy even if the effects of IPV treatment within the coordinated community response have not been precisely isolated and may vary across populations and contexts.

Given (a) the tendency to isolate specific risk variables for IPV recidivism using quantitative prediction models (such as linear regression), (b) the relative absence of empirically based cutoffs for risk prediction with this population, and (c) the limited amount of research on patterns of correlated risk variables, it is not surprising that we know very little about the risk profiles of most offenders who do not engage in recidivist IPV. For example, do such individuals possess some, few, or none of the common risk factors for IPV recidivism? Also, assuming that specific variables are predictive of IPV recidivism across populations and contexts, do the same levels or scores on these variables convey similar risk, or are different cutoffs needed to detect low- and high-risk cases in different contexts?

Many recidivism risk factors are linked to poor general impulse control, reflected in problems such as anger dysregulation (Birkley & Eckhardt, 2015; Murphy, Taft, & Eckhardt, 2007) and head injury, or to poor situational impulse control, reflected in factors such as acute alcohol intoxication (Jones & Gondolf, 2001). Under the assumption that low-risk individuals tend not to possess as many of these characteristics, we can speculate that they have more intact self-regulation mechanisms and are therefore likely to end their use of physical IPV in response to various elements of the standard community intervention system. Although group is currently the more commonly prescribed format, couples counseling is allowed in some states and has been proven effective with this low-risk offender population.

Existing interventions may also be well matched to the needs of these low-risk offenders, provided that they incorporate the basic, empirically supported research findings discussed in this review. For example, weekly group psychoeducation to enhance relationship skills and reduce coercive and controlling behavior may be a good fit for individuals who do not have significant complicating problems such as substance dependence or intense emotion dysregulation—particularly if those groups are facilitated by clinicians who are capable of fostering a strong therapist–client alliance and can maintain a cohesive and productive group experience. Establishing a strong facilitator–client alliance requires that facilitators employ a flexible treatment approach to address, as much as possible, the individual treatment needs of their clients. This can be achieved even when working with a set curriculum, provided that a thorough assessment is conducted, personal goals are established for each client, and provisions are made for referring clients to any necessary adjunct therapeutic services (see Hamel, in press). When conducted in this way, "one-size-fits-most" is, in effect, closer to differential treatment as previously discussed. For example, batterer intervention clients at one Northern California program (Hamel, 2014) are required to complete an initial assessment consisting of validated instruments that include the Conflict Tactics Scales, the CAT Questionnaire, the Safe at Home Questionnaire, and the ECR Questionnaire to measure, respectively, each client's history of physical aggression, emotional abuse and controlling behaviors, readiness to change, and attachment style (Hamel, 2014):

> The group facilitator reviews these following the initial session and gives the client feedback about the results in the second session, either in front of the whole group, or in a private meeting after group, depending on client preference. Clients are asked to enter their scores in the "My Profile" section of their workbooks (see Appendix C), and urged to use those scores to set their own goals for treatment. They are told that they will be readministered some of these instruments prior to their final exit interview at program completion. We believe that this process is in keeping with research-based MI principles and good evidence-based practice (Shlonsky & Gibbs, 2004), in providing each client special attention and enhancing the facilitator-client alliance. An internal review of BIP clients enrolled in our various San Francisco Bay area locations between 2009 and 2013 found an overall increase in client functioning, based on a comparison of pre- and post-program scores, in self-perceived higher levels of motivation to accept responsibility for their behaviors, ability to better manage anger and resolve interpersonal conflicts peacefully, and lessened use of emotional abuse and control tactics. (p. 122)

It is also quite probable that subtle variations in program structure or approach will have limited impact on individuals who have intact self-control and are motivated to avoid further legal sanctions or negative personal consequences from continued violence. The idea that "one-size-fits-most" leads to several important research priorities.

One is to develop procedures that can accurately detect individuals who are at low risk for IPV recidivism. Ideally, such assessments should be user-friendly to support adoption by program practitioners with the levels of training and experience recommended earlier in this review. Second, it will be important to identify the duration and intensity of intervention that is sufficient to promote and maintain violence cessation for low-risk cases. There may be ways to accomplish this goal without the need for a lengthy series of experimental trials to compare different program lengths, for example, through analyzing outcome data from existing programs that vary in length or intensity to look for the point(s) of diminishing returns for continued intervention. The tendency in the field to date, as reflected, for example, in the 52-week requirement in California IPV program standards, has been to assume that if a reasonable amount of intervention is not effective for everyone, then everyone should receive more of the same. This assumption is problematic on many levels, including the idea that everyone needs more intervention and the idea that something that is not working in a lower dose will be effective in a higher dose.

Finally, it will be important to formulate a reasonable set of intervention strategies that are sufficient to promote violence cessation for low-risk offenders. This may be accomplished in several ways, including the use of qualitative and client-satisfaction studies to elicit subjective appraisals of helpful and unhelpful intervention methods among successful outcome cases and by looking for empirical examples suggesting unfavorable outcomes or potentially dangerous intervention practices within existing intervention and evaluation studies.

New Approaches to High-Risk Offenders. The prognosis for high-risk offenders contrasts starkly with that of low-risk offenders. Available evidence, reviewed earlier, indicates that a small proportion of IPV treatment cases accounts for a great majority of recidivist violence incidents. It is not clear that any intervention approach has had a significant benefit in reducing violence for this subpopulation of offenders. This latter point relies on some assumptions about treatment for nonresponders. Studies using various treatment approaches and formats have produced similar findings in which a modest proportion of cases have very poor outcomes involving frequent and/or severe IPV recidivism. It remains possible that these poor outcome cases reflect different subgroups of offenders in different studies or different intervention conditions. However, this seems unlikely given that there are several risk factors that consistently predict poor treatment outcome across different interventions.

Therefore, the most likely conclusion is that existing IPV treatments are not having their intended effects on these high-risk cases. Existing interventions may be insufficiently intense to promote violence cessation for these individuals, insufficiently responsive to their specific risk profiles and needs, or somehow misguided in their approach to high-risk cases. There is a pressing need for research to develop straightforward and practical assessment strategies that can accurately detect individuals at high risk for IPV recidivism, to examine monitoring and case management strategies that can reduce acute or imminent risk for repeat violence, and to test intervention

strategies that are sensitive to the specific needs of high-risk cases. Obviously, no intervention will be successful with everyone, and it is important to have realistic expectations, particularly for individuals with long histories of criminal involvement and antisocial behavior. However, the literature to date contains very few examples of efforts to develop and test interventions specifically targeting the subpopulations of IPV offenders who present the highest risk for recidivist violence.

Two encouraging recent trends suggest that the field is moving in the direction of targeting key risk factors for IPV recidivism. One trend involves the use of intervention approaches focused on enhancement of emotional and behavioral self-regulation. A recent study demonstrating the efficacy of ACT for IPV relative to an attention placebo control condition is an excellent example of this trend (Zarling et al., 2015). Notably, their study showed that reductions in abusive behavior associated with ACT were, in part, explained by reductions in emotional dysregulation and experiential avoidance. As noted earlier, however, their study had a somewhat unusual sample for IPV intervention research, being majority female, voluntarily referred, and help seeking within a mental health context. Thus, the extent to which their sample represented cases at high risk for recidivism remains unclear.

A second trend involves efforts to target substance use problems, most notably alcohol dependence, in the context of IPV intervention. Longitudinal studies have isolated alcohol abuse as a very strong risk marker for recidivism (e.g., Jones & Gondolf, 2001). A recent study by G. L. Stuart and colleagues (2013) provides a nice example of this trend. They identified IPV offenders in community treatments with problematic drinking patterns and randomized them to receive either treatment-as-usual or a brief (90-minute) intervention consisting of structured assessment feedback about their drinking and MI to stimulate change. Despite the very brief (and relatively low-cost) nature of the intervention, those who received the alcohol treatment displayed lower rates of drinking and partner violence over the subsequent 6 months. However, significant benefits were not sustained through a 12-month follow-up. These findings are not only encouraging for identifying and addressing problem drinking as a key risk factor for IPV recidivism but also suggest a need for more extensive and intensive approaches in concert with IPV intervention.

Trauma-Informed Treatment. Many of the individuals in the severe subtypes of IPV offenders (e.g., dysphoric/borderline and generally violent/antisocial groups) have significant histories of trauma. Adverse childhood experiences, most notably experiencing child abuse or witnessing interadult aggression in the home, have been linked to IPV perpetration through an extensive body of research. Traditional explanations emphasize social learning of violence through childhood exposure. However, an emerging literature recasts these childhood experiences as traumatic stress exposures. Using broader assessments of traumatic stress, clinical studies indicate that 75%–90% of male IPV perpetrators report exposure to one or more event that would meet *Diagnostic and Statistical Manual* (*DSM*) definition of trauma exposure (Criterion A for the diagnosis of PTSD; Hoyt, Wray, Wiggins, Gerstle, & Maclean,

2012; Maguire et al., 2015; Semiatin, Torres, LaMotte, Portnoy, & Murphy, in press). In addition, military veterans with PTSD have rates of partner violence that are about 3 times higher than the rates observed among veterans without PTSD (Taft, Watkins, Stafford, Street, & Monson, 2011). PTSD symptoms in IPV offenders are associated with greater extent and severity of abuse perpetration, greater relationship dysfunction, more generalized violence, and greater problems with alcohol and other drugs (Semiatin et al., in press).

These findings highlight the need for intervention approaches that are sensitive to the potential effects of traumatic stress among IPV perpetrators (Taft, Murphy, & Creech, 2016). Toward this end, a recent trial conducted within two Veterans Affairs' (VA) hospitals randomized 135 U.S. military veterans to receive either enhanced VA care as usual in a wait-list control group or a 12-session, trauma-informed group CBT intervention called *Strength at Home* (Taft, Macdonald, Creech, Monson, & Murphy, 2015). About half of the sample had diagnosable levels of PTSD, and all reported some form of trauma exposure. The results demonstrated significantly greater reductions in physical and emotional abuse for veterans who received the Strength at Home program. These encouraging initial findings highlight the need for more research to examine the impact of trauma-informed and trauma-focused treatments for IPV within community settings.

Qualitative Analyses of Treatment Nonresponders and Recidivist Violent Incidents. To develop more effective IPV interventions, we may need a fuller and richer understanding of the missing and misguided elements of existing approaches. Large-scale quantitative prediction studies have been very useful in understanding risk factors for violence recidivism. However, we know relatively little from an "insider's" perspective about this process. For example, it would be helpful to know how recidivist offenders experienced the IPV intervention program and whether some elements or aspects of these programs are alienating to these individuals. Likewise, it would be interesting to determine what goes wrong for offenders who are engaged and active participants in IPV services yet have significant repeat violence. It is possible that in-depth analysis of recidivism and specific instances of recidivism may provide additional guidance for program enhancements.

Strategies to Increase Voluntary Referrals and Forms of Help-Seeking That Do Not Rely Exclusively on the Criminal Justice System. It is a great thing that police, prosecutors, and probation agents take IPV much more seriously than they did 40 years ago and that IPV is widely treated as criminal behavior rather than a private matter between lovers. Despite the significant social changes were hard fought by activists in the shelter and battered women's movement, the struggle for social justice for survivors of partner violence is far from over. The use of court-mandated intervention services for perpetrators of IPV will likely remain an important alternative for many reasons, including the desire to minimize the negative effects of incarceration on families.

Nevertheless, there is a tremendous need to develop sustainable systems of care for both survivors and perpetrators of intimate violence that are not fully reliant on the criminal justice system. Currently, many states with mandatory arrest and no-drop prosecution policies (such as California) do not allow for a diversion option, by which first-time, lower level offenders can be persuaded to enter treatment in lieu of a criminal conviction. Results of a large survey of U.S. IPV intervention programs found that the average program receives 89% of their referrals from the court, and about half of all programs receive more than 95% of referrals that way (Price & Rosenbaum, 2009). There is simply no socially acceptable process for individuals who have engaged in partner violence to ask for help. The development of a system of care for IPV perpetrators who are not yet court involved might require important innovations and significant research. There is a need for extensive social messaging, not merely to show that violence is wrong but to raise public awareness that it is OK to ask for help. Similarly, although there have been dozens (perhaps hundreds) of studies examining IPV screening for victims within health care settings, there is virtually no research on IPV screening for perpetration. One possible reason is that doctors and nurses prefer a clear process by which to refer individuals who screen positive for perpetrating violence. Another may be that health professionals need proper training to be comfortable with this type of conversation. In addition to general medicine, extensive data highlight the need for better service referrals or service provision within specialty care for individuals with conditions that are linked to increased risk for IPV, including substance dependence, PTSD, and mood disorders.

Although these points may seem only tangentially relevant to the development of model standards for IPV intervention with court-mandated populations, one potentially important topic for further research involves the value of having both voluntary and court-referred participants receiving services together. Self-referred cases tend to report higher motivation to change at the outset of treatment and tend to be more forthcoming on initial assessments (Rosenbaum et al., 2001). It is possible that a better balance of self- and court-referred cases may produce a more constructive atmosphere in treatment groups. As noted earlier, the use of clinical strategies designed to motivate change and resolve ambivalence about the need for change appear to increase the efficacy of standard IPV interventions by enhancing engagement into the active elements of treatment. We also need concerted and sustained research efforts to devise effective strategies to establish referrals from individuals who have not yet become involved with the court system.

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