Proposed Evidence-Based Standards for Domestic Violence Perpetrator Programs in the United States: Summary of Recommendations

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General Conclusions and Recommendations	• Partner abuse (PA) can take the form of discrete physical and non-physical assaults or a pattern of such assaults, and often includes a pattern of coercive control of the relationship partner. • 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. • Victims include child witnesses and the entire family system • Physical PA, sexual abuse, and some forms of emotional abuse, are criminal offenses. • Holding offenders accountable requires a multi-system response, including effective policing, prosecution, incarceration, judicial monitoring, and/or treatment. • Perpetrator treatment is one part of a coordinated community response that includes law enforcement, victim advocates, mental health professionals and other social service agencies. • 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. • Treatment should be delivered by providers with substantial and accurate knowledge of partner abuse, including prevalence rates, abuser characteristics, causes and contributing factors, dynamics, and the negative impact on victims and families. • Perpetrator treatment plans should be determined through a thorough psychosocial assessment that includes, but is not limited to, known PA risk factors. • Treatment should be based on current best practices informed by empirical research on treatment outcome, treatment engagement, and risk factors for PA recidivism.
Overall effectiveness	• 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 policy-makers 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	• 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 a variety of 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	• 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 post-treatment violence, may not be possible with large groups.
Group format and curriculum	• Known risk factors should provide a basis upon which to identify and assess potential educational components. • The following risk factors were identified along with interventions with demonstrated efficacy. 1) Stress, especially from low income and unemployment; 2) Having an aggressive personality characterized by a desire to dominate, hostility toward the opposite sex or attitudes that support violence; 3) Poor impulse control; 4) Depression; 5) Emotional insecurity; 6) Alcohol and drug abuse; 7) Having witnessed violence between one's parents as a child, or having been abused or neglected by them; and 8) Being in an unhappy or high conflict relationship.
Assessment protocol and instruments	• 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 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	• Whenever possible, it is important to obtain information on perpetrator recidivism from the victims. • BIP programs 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	• 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	Step 1. Determine the Type of Violence • Male perpetrated vs female perpetrated • Self-defense • Mutual combat • Controlling/Coercive Violent (Intimate terrorism) Step 2. Determine Characteristics of Perpetrators • Generally-violent versus family-only • Borderline personality characteristics (generalized affect regulation problems) • Attachment difficulties (relationship specific affect regulation problems) Impulse/anger control difficulties • Power and control motivation • History of substantial head injury

<table>
<tr><td></td><td>Step 3: Determine presence of alcohol or substance abuse, and if present refer to treatment prior to proceeding with intimate partner violence treatment

Step 4. Make Treatment Decision Based on Above
• 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 intimate partner violence
• 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
✓ Motivational Interviewing
• 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 i.e., relationship with parents
✓ Address history of loss within intimate relationships
✓ Address insecure attachment or avoidant attachment issues
• If Family-Only With Borderline Tendencies
✓ Dialectical behavior therapy
✓ Mindfulness
✓ Affect regulation skills</td></tr>
<tr><td>Working with female perpetrators</td><td>• 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.</td></tr>
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Working with Racial and Ethnic Minority Groups	• 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 LGBT perpetrators	• Substantially more data should be collected on the characteristics and needs of LGBT populations (especially transsexuals). • 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 in order to better understand and frame the problem of IPV in LGBT communities • BIPs ought to develop and utilize 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.
Practitioner-Client Relationships	• 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. Motivational interviewing is likely to be very helpful in these efforts.
Required Group Facilitator Education and Training	• 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 forma

	• Facilitators should be familiar with the heterogeneity of both intimate partner violence and characteristics of perpetrators, and have exposure to different models accounting for the development and maintenance of intimate partner violence. • 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 Partner Abuse State of Knowledge literature reviews (www.domesticviolenceresearch.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 3 or more therapy clients or groups ✓ Supervision of non-therapists 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 an MA level 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 completed the 40-hour classroom training and hands-on 52-week supervised training.