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

(Summary of Recommendations; pre-publication draft, June 15, 2016)

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Abstract

In the United States, the judicial system response to violence between intimate partners, or 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. Over 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 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, IPV, domestic violence, perpetrator treatment, BIP standards

III – Conclusions and Implications for Treatment Standards

General Recommendations

1. 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.
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 multi-system 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 partner abuse, 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 BIPs

With respect to treatment effectiveness neither previous (Babcock, Green & Robie.,2004 and Feder & Wilson., 2005), nor more recent meta analyses/reviews (Eckhardt et al.,2013; Arias et al, 2014)), 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 non-significant effects (Arias et al 2014), 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 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

A recent survey of BIPs in the United States and Canada, Buttell et al. (2015) 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 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

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 co-leader 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 post-treatment 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 post-treatment 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 provide them with skills to heal past trauma.

Outcome studies find CBT programs, which incorporate into their curriculum emotion management, communication and conflict resolutions skills, have been found to be marginally more effective than feminist/power and control models such as Duluth (Miller, Drake & Nafziger, 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 (Stewart, Flight & Slavin-Stewart, 2013).

Recommendations:

- 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

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, Bonta, & Wormith, 2009) is noted. There exist a variety of useful instruments to assess specific áreas 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 (Preventative Services Task Force 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)[1] 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 (Dutton & Kropp, 2000; Bowen et al, 2011; Hanson, Helmus, & Bourgon, 2007; Nicholls et al., 2013) is insufficient to recommend a single IPV risk assessment tool with well-established psychometric properties towards 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 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 in order 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 connecting victims to the broader aspects of BIP programs 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, Green, & Robie, 2004), some states allow contact and some do not due to victim safety concerns. However, no studies to date have explored the impact of contact policies on victim safety. Additionally, 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. 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 that 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
- 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

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 (Buttell et al., 2016). While 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 (Buttell 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; O'Leary, Pan, & Neidig, 1999; Dunford, 2000), Domestic Violence Focused Couples Treatment (DVFCT; Stith, Rosen, McCollum, & Thomsen, 2004), non-aggression-focused behavioral couple therapy (Simpson, Atkins, Gattis, & Christensen, 2008), brief motivation-focused interventions (Woodin & O'Leary, 2010), and interventions based on Gottman principles such as communication, conflict management, intimacy/friendship, and creating a shared meaning (Bradley, Friend, & Gottman, 2011; Bradley & Gottman, 2012; Wray, Hoyt, & Gerstle, 2013; Adler-Baeder, Robertson, & Schramm, 2010), 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 multi-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 intimate partner violence 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, Webb, Shumway, Block, & Nakamura, 2009

There is need for openness to varied theoretical orientations, and some that seem worthy of more extensive evaluation include individualized treatment and motivational interviewing approaches (Murphy, Meis & Eckhardt, 2009), couple approaches (Hamel & Nichols, 2006; Salis & O'Leary, in press; Stith, McCollum & Rosen, 2011) , individual approaches followed by couple approaches (Geller, 1992; Salis & O'Leary, in press; Stith, McCollum & Rosen, 2011), cultural context and family systems approaches (Almeida & Hudak, 2002), and acceptance and commitment based approaches (Zarling, Lawrence & Marchman, 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 & O'Leary (2014).

Recommendations:

Step 1. Determine the Type of Violence: (Kelly & Johnson, 2008)

- 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 (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 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 (McCollum & Stith, 2008; Simpson, Atkins, Gattis, & Christensen, 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
  - ✓ Motivational Interviewing (Scott et al. (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 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 (Cavanaugh, Solomon, & Gelles, 2011; Fruzzetti & Levensky, 2000; Kliem, Kröger, & Kosfelder, 2010; Tollefson et al., 2009; Tollefson & Phillips, 2015):
  - ✓ 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, 2004a) 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, 2004b, 2006; Tutty, Babins-Wagner, & Rothery, 2006, 2009; Wray, Hoyt, & Gerstle, 2013) and there have been no randomized controlled trials evaluating court-mandated treatments for female perpetrators of IPV. Across studies there are some promising effects of BIP's for women in terms of psychological variables and reductions in non-physical forms of abuse. However, we have no evidence that BIP's for court-mandated women effectively reduce their own use of physical violence toward partners. The only evidence for reduction of physical perpetration of intimate partner violence comes from interventions addressing at risk parenting with women referred for parenting issues. Acceptance and Commitment Therapy 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, Leisring, & Rosenbaum, 2005; Henning, Jones, and Holdford, 2003; Stuart, Moore, Gordon, Ramsey, & Kahler, 2006). Like men, most partner-aggressive women are in bi-directionally 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 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, while 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 (Williams, Oliver, & Pope, 2008, Schafer et al., 2004, Caetano et al., 2000; Cunradi et al., 2002), 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/a community. however, results should be considered inconclusive at best as the available literature presents varying and often conflicting findings (Caetano, Cunradi, Clark, & Schafer, 2000; Cunradi, Caetano, Clark, & Schafer, 1999; Hancock & Siu, 2009; Field, Caetano, 2005; Caetano, Field, Ramisetty-Mikler, & Lipsky, 2009; Cunrandi, Caetano, & Schafer, 2002; Caetano, Schafer, Field, & Nelson, 2002; Cunradi, Caetano, Clark, & Schafer, 2000; Ferguson, 2011; Sugihara & Warner, 2002; Kim-Goodwin & Fox, 2009; Duke & Cunradi, 2011). 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 LGBT 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 since the latest NIPSV survey 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 in order 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 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.

Perpetrator Treatment and Practitioner-Client Relationships

A small number of studies in the probation criminal justice field (e.g. Keneally, Skeem, Manchak, & Eno Lauden, 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 intimate partner violence 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, Norsworthy, & Rowlands, 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 themselves, 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 a Motivational Interviewing (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).

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. Motivational interviewing 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, 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, 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 National Coalition Against Domestic Violence (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 develop concepts, and create knowledge environments, as well as the use of on-line 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 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.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 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 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 versus individual), facilitator education and training, and facilitator arrangements (e.g., single versus dual facilitators; same versus 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, etc. 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 post-traumatic 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. LBGTQ populations are likewise seriously under-represented in existing IPV intervention research. The review also reveals a substantial need for research on program adaptations and culturally-focused interventions within the U.S. 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 policy makers 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 IPV 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) Risk-Need-Responsivity (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 multi-disciplinary team with victim advocates and legal system representatives. The multi-disciplinary 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 above) 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, 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 1-2 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 the majority of IPV offenders. These findings suggest that a "one-size-fits-most" approach involving a coordinated community response has significant merit. Further, 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 et al., 1997). 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 the majority of 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, Eckhardt & Taft, 2007) and head injury (Akerele, Williams, & Murphy, under review), 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 a various elements of the standard community intervention system. While 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 some of 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 in order 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 adjunct therapeutic services (see: Hamel, 2016). When conducted in this way, "one-size-fits-most" is, in effect, much closer to the differential treatment suggestions 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 Controlling and Abusive Tactics Questionnaire, the Safe at Home Questionnaire, and the Experiences in Close Relationships 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 re-administered 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 a number of 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 above, 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 non-responders. Studies using a variety of 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 a number of 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 Acceptance and Commitment Therapy for intimate partner violence 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 dysegulation 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 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 motivational interviewing 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 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 inter-adult 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 re-casts 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 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, Creech & Murphy, in press). Toward this end, a recent trial conducted within two 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, in press). 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 non-responders and recidivist violent incidents. In order 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 intimate partner violence 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.